EXAMINING THE FEDERAL GOVERNMENT'S FAILURE TO CURB WASTEFUL STATE MEDICAID FINANCING SCHEMES

HEARING

BEFORE THE

SUBCOMMITTEE ON ENERGY POLICY, HEALTH CARE AND ENTITLEMENTS

OF THE

COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM

HOUSE OF REPRESENTATIVES

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EXAMINING THE FEDERAL GOVERNMENT'S FAILURE TO CURB WASTEFUL STATE MEDICAID FINANCING SCHEMES

Tuesday, July 29, 2014,

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON ENERGY POLICY, HEALTH CARE AND ENTITLEMENTS,
COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM,
Washington, D.C.

The subcommittee met, pursuant to notice, at 10:00 a.m. in room 2154, Rayburn House Office Building, the Honorable James Lankford [chairman of the subcommittee], presiding.

Present: Representatives Lankford, Walberg, Woodall, Cummings, Speier, Norton, Duckworth, Lujan Grisham, Davis and Maloney.

Staff Present: Brian Blase, Majority Senior Professional Staff Member; Will L. Boyington, Majority Deputy Press Secretary; Meinan Goto, Majority Professional Staff Member; Jessica Seale, Majority Digital Director; Matthew Tallmer, Majority Investigator; Sarah Vance, Majority Assistant Clerk; Una Lee, Minority Counsel; Suzanne Owen, Minority Senior Policy Advisor; and Michael Wilkins, Minority Staff Assistant.

Mr. LANKFORD. The committee will come to order.

Without objection, the Chair is authorized to declare a recess of the Committee at any time.

Good morning.

I want to begin this hearing by stating the Oversight Committee Mission Statement. We exist to secure two fundamental principles. First, Americans have the right to know that the money Washington takes from them is well spent. Second, Americans deserve an efficient and effective government that works for them.

Our duty on the Oversight and Government Reform Committee is to protect these rights. Our solemn responsibility is to hold government accountable to taxpayers because taxpayers have a right to know what they are get from the government.

We will work tirelessly in partnership with citizen watchdogs to deliver the facts to the American people and bring genuine reform to the Federal bureaucracy.

This is the mission of the Oversight and Government Reform Committee.

Today's hearing of the Subcommittee on Energy Policy, Health Care and Entitlements is dealing with Medicaid. In the last Congress, this committee held five hearings on waste, fraud, abuse and

mismanagement in the Medicaid Program. At those hearings, we highlighted tens of billions of dollars that are unaccounted for or improperly paid annually.

The goal of today's hearing is to get an update on progress, discuss additional oversight needs and hear what will be done to prevent improper payments in the future.

In the past, we learned that Texas' Medicaid program was spending more on kids' braces than the rest of the state's Medicaid programs combined and that both state and Federal Government were blind to the problem until a Texas news story came out.

We learned that CMS approved Medicaid managed care rates in Minnesota well in excess of what was actuarially appropriate.

We learned that payment rates for New York State operated developmental centers rose to more than $5,000 per patient per day, ten times higher than the rates received by private facilities in New York that perform similar functions. In 2012, taxpayers paid nearly $2.5 billion for about 1,300 patients residing in these facilities.

In March of last year, the Committee released a bipartisan report estimating that the state received $15 billion above the legally permissible amount over a two decade period through these high payment rates.

On a bipartisan basis, the Committee urged CMS to end the overpayments moving forward and to recover an appropriate amount of past overpayments. This past Friday, CMS announced its intention to recover nearly $1.3 billion in excess developmental center payments for 2010 from New York alone.

We applaud CMS' actions and we encourage CMS to continue to recover the full amount due to the federal taxpayer from both 2011 and 2012.

Over the past two years, at this committee's request, the Government Accountability Office and Health and Human Services' Inspector General's Office have both conducted work to shed greater light on Medicaid spending. Today, they will present their findings and recommendations.

All states take advantage of the extremely complicated Medicaid financing rules to one degree or another to maximize federal Medicaid money flowing into their state. At the root of the problem is an uncapped federal reimbursement of State Medicaid spending. Unfortunately, this problem is likely to get much worse with Obamacare's Medicaid expansion.

Today's hearing will show that Medicaid Program financing needs and fundamental reform, not a blanket expansion of the program itself.

GAO will provide evidence that state financing schemes over the past five years shift costs to the federal taxpayer. GAO will provide testimony that CMS cannot monitor whether state financing techniques and Medicaid payments to providers comply with legal requirements because the data CMS collects is insufficient.

GAO will also provide testimony that government providers tend to receive substantially higher Medicaid payments than private providers. For instance, GAO found two local government hospitals in New York City that received $400 million in Medicaid supple-

mental payments in 2011 and had an average daily payment rate nearly ten times the amount of private hospitals in the state.

The Inspector General will provide testimony about its findings from several audits of New York's Medicaid program, including a finding that state operated residential centers receive hundreds of millions of dollars above costs each year.

The large payments received by these two local government hospitals and the state operated residential centers undoubtedly violate Title 19 of the Social Security Act which mandates that Medicaid payment rates must be efficient and economical.

The high rates also violate Medicaid upper payment limit requirements which prohibit states from claiming federal matching funds for Medicaid payments that are in excess of what Medicare would have paid for similar services.

These examples raise serious questions about the ability of CMS to effectively oversee State Medicaid spending. How does CMS continue to fail to detect State Medicaid spending that is clearly not efficient and economical and that violates Medicaid upper payment limits?

What does CMS plan to do about the GAO and IG findings that will be presented here today?

Finally, what steps will CMS take to monitor state financing and payment schemes during Obamacare's Medicaid expansion?

All this is a part of our conversations. As I shared with the witnesses earlier today, this will be our conversation during this time period. We want to be able to get to the facts and the process.

Billions of taxpayer dollars are at stake in this process and all of us have a commitment to be able to take care of those in greatest need but we all have a commitment to be able to honor the federal taxpayer in the process.

I thank the witnesses for being here today and look forward to all of your testimony.

With that, I will recognize the distinguished Ranking Member, the gentlelady from California, Ms. Speier, for her opening statement.

Ms. SPEIER. Thank you, Mr. Chairman. Thank you to all the witnesses who have joined us today.

Tomorrow is the 49th anniversary of the Medicaid Program. In 1965, this country made a pledge to low income working and disabled Americans that they would have a safety net to provide for their basic health care needs.

This partnership between the state and federal governments has delivered on its promise for nearly 50 years, providing critical medical services to the most vulnerable Americans.

Under the Affordable Care Act, we have extended this commitment to millions more Americans. This year, states were able to expand Medicaid to all adults under 65 with incomes up to 138 percent of the federal poverty level. We are talking about a person with an income of approximately $16,000 annually or a family of four with an income of $32,900.

For these newly eligible enrollees, the Federal Government will pick up 100 percent of the cost of the expansion from 2014 to 2016 falling gradually to 90 percent by 2020. Twenty-seven states have decided to expand Medicaid. That is a majority of the states in this

country, including a number of Republican controlled legislatures and governors.

For example, recently Governor Kasich announced his decision to expand Medicaid in the state of Ohio stating, "It is going to save lives. It is going to help people. You tell me what is more important than that."

To the detriment of their state bottom lines, some governors and state legislatures are so blinded by hostility towards the ACA that they overlook the compelling moral and economic reasons to expand Medicaid.

Similarly, many congressional Republicans view the ACA Medicaid expansion as well as the Medicaid Program generally as an anathema. Today, we will hear a number of arguments about why Medicaid should be cut or turned into a block grant. Let us remember we are talking about people making $16,000 a year.

First, Republicans argue that Medicaid's costs are growing out of control but average annual Medicaid cost growth per beneficiary over the last 30 years has been no greater than the growth of health care cost systemwide.

In fact, Medicaid's cost growth per beneficiary has been growing slower than cost in the private insurance market.

Second, Republicans argue that the financing structure of Medicaid is highly vulnerable to gaming by states that use financing mechanisms to maximize federal funding. Some examples they point to include the use of intergovernmental transfers, IGTs, certified public expenditures, CPEs, and provider taxes.

Therefore, my colleagues argue, the only way to control federal Medicaid costs is to block grant funding.

It is important to point out that under the current statutes and regulations, provider taxes, intergovernmental transfers and certified public expenditures are entirely legal and permissible ways to finance the non-federal share of Medicaid.

Nearly all 50 states use these financing mechanisms and have done so for decades. Moreover, the Federal Government has taken a number of steps over the past two decades to limit these mechanisms.

Legislation enacted in 1992, 1997, 2000 and 2006, as well as federal regulations and guidances have imposed restrictions on states' abilities to draw down additional federal Medicaid funds.

I am not saying that Medicaid is perfect. One problem I repeatedly hear about is that Medicaid pays providers much less than what Medicare pays. Even after factoring the Medicaid Supplemental Payment Program, California hospitals provided nearly $14 billion in uncompensated care in 2011.

This figure includes $5.2 billion in losses due to the difference in cost of caring for Medi-Cal patients and what the program pays hospitals for those services.

Although the problem of uncompensated care is particularly acute in California, uncompensated care costs and Medicare reimbursement rates are an issue for providers nationwide.

Any effort to restrict state financing of the non-federal share of Medicaid or change the upper payment limits must be considered in this context and in the context of how such changes will affect providers who are already struggling to keep the doors open.

I appreciate that today we are looking at the cost implications to the Federal Government by examining legitimate and legal practices that states use to fund their non-federal share of Medicaid. But if we are serious about preventing and identifying waste, fraud and abuse, there is so much more that we could be doing.

We are currently being penny wise and pound foolish if we do not fully fund the HHS Inspector General's fiscal year 2015 budget request which is one of the best tools we have for identifying waste, fraud and abuse.

I look forward to hearing from GAO and OIG regarding their concerns and recommendations and from CMS regarding what the agency is doing to improve federal oversight of state financing of Medicaid costs.

I also look forward to hearing about any additional actions that Congress should take to address these issues.

With that, I yield back.

Mr. LANKFORD. Members will have seven days to submit opening statements for the record.

I would like to enter two additional items into the record. This is the July letter from the Office of Inspector General relating to the questions we asked. This is the July Medicaid Financing Report from the GAO. Without objection, so ordered.

We will now recognize our first and only panel in this conversation.

Ms. Katherine Iritani is the Acting Director of the Health Care Team for the Government Accountability Office. Thank you for being here.

Mr. John Hagg is the Director of Medicaid Audits in the Office of Inspector General, Department of Health and Human Services. Thank you as well.

Ms. Cindy Mann is Deputy Administrator and Director at theCenter for Medicare and the Children's Health Insurance Program Services for the Center for Medicare and Medicaid Services.

Thank you all for being here.

Pursuant to Committee rules, all witnesses are sworn in before testifying. Please stand and raise your right hand.

Do you solemnly swear or affirm that the testimony you are about to give will be the truth, the whole truth, and nothing but the truth so help you God?

[Witnesses respond in the affirmative.]

Mr. LANKFORD. Thank you. You may be seated.

In order to allow time for discussion, I would ask you to limit your testimony to five minutes. You have all given extensive written testimony as well. That will be made a part of the permanent record.

You may deviate from what you said in your written testimony although we would like for it to at least be consistent factually. This conversation is yours to be able to share additional oral testimony with us.

The Chair will recognize Ms. Iritani first for her five minutes.

WITNESS STATEMENTS

STATEMENT OF KATHERINE IRITANI

Ms. IRITANI. Thank you, Mr. Chairman.

Chairman Lankford, Ranking Member Speier and members of the subcommittee, thank you for the opportunity to be here as you examine how states can shift Medicaid costs to the Federal Government.

The over $400 billion Medicaid Program has been on GAO's list of high risk programs since 2003. A contributing reason was concerns we had about federal oversight of complex state medicaid financing and payment arrangements.

Medicaid provides care to our Nation's most vulnerable citizens. As such, ensuring the program's long term sustainability is very important. My remarks today will focus on our new report on state medicaid financing and ongoing work on state medicaid payments to government providers.

The bottom line of our recent work is a message about the need for transparency. There are significant gaps in data to understand both the broader picture of the extent to which states rely on different sources to finance their share of Medicaid payments and the more detailed picture of what Medicaid providers are actually getting paid.

These gaps in data exist on the financing side and on the payment side.

On the financing side, CMS lacks data on state reliance on funds they are obtaining from providers and local governments to finance the non-federal share. Within certain limits, states are allowed to tax providers and seek contributions from local governments to obtain funds for Medicaid.

For providers, the payment they receive is the net payment, that is, what Medicaid pays them less their contributions toward Medicaid. states can ultimately shift more of the burden of Medicaid cost to the Federal Government by financing new payments with funds from Medicaid providers and local governments.

States are required to report provider taxes to CMS but data are incomplete and unreliable. states are not required to report amounts of contributions from local governments.

The need for better data on financing is underscored by results of our national survey of state medicaid programs. states reported they are increasingly relying on providers and local governments to help finance Medicaid.

In 2012, about $46 billion or 26 percent of the non-federal share of Medicaid was financed with funds from providers and local governments, a 21 percent increase from 2008. Provider taxes almost doubled in size during that time from $9.7 to $18.7 billion. These changes are allowable within certain limits but have important implications for federal costs.

In one example, the state financed an estimated $220 million increase in payments to nursing facilities with only a provider tax on those facilities plus federal matching funds.

Now to discuss the payment side. CMS also needs better visibility into state medicaid payments. States can have incentives to

shift costs to the Federal Government by overpaying certain providers such as state or local government hospitals.

In doing so, they can leverage federal matching funds for the excessive payments and reduce the need for state funding.

Our ongoing work examining Medicaid payments to government providers has been challenged by the lack of good data. At the federal level, certain types of large payments that states often make are not captured in claims data, nor is data on the ownership status of providers.

Payment data maintained only by states are not always reliable or very accessible. The need for better data on payment is underscored by the preliminary results from one analysis we have been able to complete of one state's payment to government and private hospitals.

This analysis suggests that local governments and hospitals in the state received average per day Medicaid payments that were 44 percent higher than those made to private providers. One outlier hospital's payments were significantly higher than others. We estimate this hospital was paid on average $8,800 per day.

Such high payments raise questions as to whether payments are for Medicaid services and are economical and efficient.

It is important to note that GAO has a longstanding body of work that has found problems in many states. A necessary step toward improving oversight and accountability in the Medicaid Program is to make payments and financing much more transparent.

Such transparency is needed for CMS, Congress and other stakeholders to better ensure that Medicaid spending is efficiently and effectively fulfilling Medicaid purposes of providing medical assistance to our Nation's low income citizens.

Mr. Chairman, this concludes my testimony and I am happy to answer any questions.

[Prepared statement of Ms. Iritani follows:]

United States Government Accountability Office

GAO

Testimony

Before the Subcommittee on Energy Policy, Health Care and Entitlements, Committee on Oversight and Government Reform, House of Representatives

For Release on Delivery
Expected at 10:00 a.m. ET
Tuesday, July 29, 2014

MEDICAID

Completed and Preliminary Work Indicate that Transparency around State Financing Methods and Payments to Providers Is Still Needed for Oversight

Statement of Katherine M. Iritani
Director, Health Care

GAO Highlights

Highlights of GAO-14-817T, a testimony before the Subcommittee on Energy Policy, Health Care and Entitlements, Committee on Oversight and Government Reform, House of Representatives

July 29, 2014

MEDICAID

Completed and Preliminary Work Indicate that Transparency around State Financing Methods and Payments to Providers Is Still Needed for Oversight

Why GAO Did This Study

Medicaid is a joint federal and state program for which the federal government matches state Medicaid expenditures. Total program costs were about $432 billion in federal fiscal year 2012. States use various sources of funds to finance the nonfederal share, such as state funds and funds from health care providers and local governments. Medicaid has been on GAO's list of high-risk programs since 2003, in part, because of concerns about federal oversight of complex state Medicaid financing arrangements where states seek funds from the providers for the nonfederal share of the payments, and oversight of large supplemental payments that states often make to government providers. States may have incentives to overpay providers that help finance the nonfederal share to maximize federal matching funds.

This statement highlights (1) findings from GAO's report being issued today on how states' reliance on health care providers and local governments to finance Medicaid changed from state fiscal years 2008 through 2012, and implications of these changes; and (2) preliminary results from GAO's ongoing work on what is known about data to oversee state Medicaid payments to government and private providers. For this work, GAO surveyed states, interviewed CMS and state officials, and reviewed information in three states selected, in part, on the basis of size, Medicaid payments, and geographic diversity. GAO shared information on its preliminary observations with CMS and incorporated comments as appropriate.

View GAO-14-817T. For more information, contact Katherine M. Iritani at (202) 512-7114 or iritanik@gao.gov.

What GAO Found

In its report being issued today (GAO-14-627), GAO found that states' reliance on funds from health care providers and local governments to finance Medicaid has increased in recent years, with implications for federal costs. In state fiscal year 2012, while most of the nonfederal share was from state general funds, states used funds from health care providers and local governments to finance 26 percent, or over $46 billion, of the total nonfederal share of Medicaid payments. States' reliance on funds from health care providers and local governments to finance the nonfederal share increased by over 21 percent from state fiscal years 2008 through 2012. States' increasing use of funds generated from health care provider taxes was one main contributing factor to this increase. States' increasing reliance on providers and local governments to finance Medicaid can effectively shift costs from the state to the federal government, as illustrated by GAO's work in three selected states. For example, in one state, a $220 million payment increase for private nursing facilities funded by a tax on private nursing facilities resulted in an estimated $110 million increase in federal matching funds and no increase in state general funds, and a net payment increase to the facilities, after paying the taxes, of $105 million.

GAO's preliminary results from ongoing work related to state Medicaid payments to government providers shows that data needed for overseeing Medicaid payments are lacking. Federal payment data do not capture on a provider-specific basis certain large supplemental payments states often make and generally lack information on provider ownership. At the state level, preliminary results in three selected states suggest that payment data primarily maintained by states are not always reliable and can be challenging to obtain and assess. GAO's preliminary analysis of Medicaid payments to government hospitals in one state suggests the need for and value of better data for oversight. GAO estimates that on an average per day basis, the state's 2011 inpatient hospital payments were higher for local government hospitals than for private hospitals. For local government hospitals, the higher average payment was largely due to supplemental Medicaid payments the state made to two local government hospitals. State officials said these hospitals served patients with greater needs. However, the state's own estimate of what Medicare would have paid these hospitals for similar services was $100 million, much less than the $416 million in supplemental Medicaid payments and $70 million in regular payments that the hospitals received. Documentation from the Centers for Medicare & Medicaid Services' (CMS) payment review process did not identify the actual supplemental payments these hospitals received. GAO plans to issue its final report later this year.

In GAO's past reports and the report being released today (GAO-14-627), GAO has made recommendations to CMS to improve Medicaid payment oversight and develop a data collection strategy to improve the transparency of state financing methods. CMS has taken steps to improve the transparency and oversight of Medicaid financing and payments but has not implemented all of GAO's prior recommendations, and has generally disagreed with GAO's new recommendation. CMS believes that additional action is not needed. As discussed in the statement, GAO continues to believe that provider-specific information on state Medicaid financing and payments is needed.

Chairman Lankford, Ranking Member Speier, and Members of the Subcommittee:

I am pleased to be here today as you explore federal oversight of state financing of Medicaid and state Medicaid payments to government providers. The size, growth, and diversity of the Medicaid program create significant challenges for administration and oversight. Medicaid is administered by states, overseen by the Centers for Medicare & Medicaid Services (CMS),[1] and financed jointly by the federal government and states based on a statutory formula. Medicaid is the nation's largest health program as measured by enrollment and the second largest health program, after Medicare, by expenditures. A significant pressure on federal and state budgets, Medicaid outlays in federal fiscal year 2012 were $432 billion, up from $352 billion in 2008.

Medicaid has been on GAO's list of high-risk programs since 2003, in part, because of these challenges and also due to concerns about gaps in federal oversight.[2] These concerns included CMS's oversight of states' complex Medicaid financing arrangements and large supplemental payments that states often make—particularly to state or local government providers such as state or county hospitals—in addition to the regular, claims-based payments. States generally finance their share of Medicaid—often called the nonfederal or state share—by using state general funds appropriated by state legislatures. However, states can, within certain federal parameters, use other sources of funds to finance Medicaid.[3] For example, they may seek contributions from local governments or impose taxes on health care providers. One concern with some of these financing arrangements is that they may create incentives for states to overpay providers in order to reduce states' financial obligations. For example, we have found that states have established complex financing arrangements to make excessive payments—often

[1]See Appendix I for a list of abbreviations used in this statement.

[2]See GAO, *High Risk Series: An Update*, GAO-13-283 (Washington, D.C.: February 2013).

[3]For example, under federal law, state funds must be used for at least 40 percent of the nonfederal share, allowing up to 60 percent to come from local government revenues. For purposes of this statement, sources of funds are the means (e.g., taxes) by which funds are supplied by entities (e.g., providers) to the state to be used to finance the nonfederal share of Medicaid; we do not use the term sources to refer to the entities themselves.

large Medicaid supplemental payments—to government providers in order to leverage federal funds for the payments.[4] In the case of state government providers, excessive Medicaid payments can reduce the state's obligation to supply funds to the provider for non-Medicaid services. In the case of local government providers, when they or local governments supply the nonfederal share of Medicaid payments, states may have an incentive to make excessive Medicaid payments to local government providers because the state has a reduced obligation to supply funds to finance the nonfederal share. Private providers that serve Medicaid beneficiaries can be taxed in order to provide funds for the state share of Medicaid payments. Generally, these taxes are levied on large providers, particularly hospitals or nursing facilities, and they are acceptable to providers because the tax revenues they supply allow the state to increase the payments they receive. As the agency overseeing Medicaid at the federal level, CMS is responsible for ensuring that state Medicaid payments made under such financing arrangements are consistent with Medicaid payment principles, including requirements that Medicaid payments be economical and efficient and ensure access to care for Medicaid beneficiaries, and that the federal government and states share in the financing of the Medicaid program as established by law. We have raised concerns about the need for improved transparency regarding the size of the payments and who receives them, as well as the need for improved accountability regarding how the funds are related to Medicaid services.[5]

You asked us to testify today on our work related to states' financing of the nonfederal share of the Medicaid program, Medicaid payments states make to government providers, and CMS oversight. My remarks will focus on our recent findings related to the following two areas of the Medicaid program,

1. the extent to which states' reliance on health care providers and local governments to finance Medicaid has changed in recent years and the implications of these changes; and

[4]See GAO, *Medicaid Financing: Long-standing Concerns about Inappropriate State Arrangements Support Need for Improved Federal Oversight*, GAO-08-650T (Washington, D.C., April 3, 2008).

[5]See GAO, *Medicaid: More Transparency of and Accountability for Supplemental Payments Are Needed*, GAO-13-48 (Washington, D.C.: Nov. 26, 2012).

2. what is known about data to oversee state Medicaid payments to government providers compared to private providers.

My testimony draws from a report we are issuing today that examines how states are financing the nonfederal share of the Medicaid program, and preliminary observations from ongoing work for this Subcommittee and the Committee on Oversight and Government Reform, House of Representatives, examining payments that selected states make to government providers.

To determine the extent to which states' reliance on health care providers and local governments to finance Medicaid has changed in recent years and the implications of these changes for the report we are releasing today, we sent a questionnaire to all states and the District of Columbia.[6] The questionnaire collected information on each state's use of funds from health care providers and local governments, state general funds, and other sources to finance the nonfederal share of Medicaid from 2008 through 2012. In addition, we obtained more in-depth information on any implications of changes in reliance on funds from health care providers and local governments from a nongeneralizable sample of three states, selected on the basis of having large Medicaid programs, as determined by spending for Medicaid services; making large amounts of certain supplemental payments to providers; having made changes in sources of funds to finance the nonfederal share, and in Medicaid payment rates from 2008 through 2011; and geographic diversity.[7] We also conducted interviews with Medicaid department officials in these states and CMS officials, including representatives from regional offices, regarding states' use of various sources of funds to finance the nonfederal share of Medicaid and CMS oversight. The findings from our in-depth analysis of the three states cannot be generalized to other states. To assess the reliability of data provided by the states, we reviewed each state's questionnaire data and in-depth information on funds from health care providers and local governments to address discrepancies and omissions, and interviewed state officials. On the basis of our review, we

[6]We fielded the questionnaire from July 2013 through November 2013, and received responses from all states. For purposes of this statement, "states" refers to the 50 states and the District of Columbia.

[7]In total, the three states' Medicaid payments were over $100 billion in 2010, or about 28 percent of total Medicaid payments that year; and the state supplemental payments totaled almost $5 billion.

determined these data were sufficiently reliable for our purposes. Assessing states compliance with federal requirements related to sources of funds for the nonfederal share was not within the scope of our review.

For our ongoing work related to what is known about data to oversee state Medicaid payments to government providers compared to private providers, we have interviewed CMS officials, including representatives from the CMS regional offices, about the oversight of Medicaid payments to government providers and the data they use. In addition, to determine how state Medicaid payment amounts to government providers compare to state Medicaid payment amounts to private providers, we are reviewing payments in the three states selected for our report on state Medicaid financing sources.[8] To date, we have reviewed one state's data for hospital inpatient services and determined that it was sufficiently reliable for our purposes. To assess these data's reliability, we discussed them with state Medicaid officials; we also clarified conflicting, unclear, or incomplete information. Our preliminary observations regarding this state's payments for inpatient hospital services are not generalizable to other types of payments made by this state or Medicaid payments made by other states. We expect to complete our work examining what is known at the federal level about payments to government providers and in selected states later this year.[9] We also obtained and reviewed documentation of CMS's review and approval of this state's Medicaid payments to government providers in 2011. Assessing whether state Medicaid payments comply with federal requirements is not within the scope of our ongoing work. We shared our preliminary observations from this ongoing work with CMS officials to obtain their views. CMS officials provided us with technical comments, which we incorporated as appropriate.

We conducted the work upon which this statement is based in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain

[8]We selected these states because the issues related to government provider payments share the same risk factors as issues related to state Medicaid financing, including having large Medicaid programs, as determined by spending for Medicaid services, and making large amounts of certain supplemental Medicaid payments to providers.

[9]Our ongoing work is also examining, in selected states, payments for inpatient hospital, outpatient hospital, nursing facility and intermediate care facilities for the developmentally disabled (ICF/DD) by provider ownership.

sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

Medicaid is an open-ended entitlement: states are generally obligated to pay for covered services provided to eligible individuals, and the federal government is obligated to pay its share of a state's expenditures under a federally approved state Medicaid plan. The federal share of each state's Medicaid expenditures is based on a statutory formula known as the Federal Medical Assistance Percentage (FMAP).[10] On average, the federal share of Medicaid service expenditures is about 57 percent. Some states design their Medicaid programs to require local governments to contribute to the programs' costs, for example, through intergovernmental transfers of funds from government-owned or -operated providers to the state Medicaid program. States may, subject to certain requirements, also receive funds to finance Medicaid payments from health care providers, for example, through provider taxes—taxes levied on providers such as hospitals or nursing facilities. For example, federal law allows up to 60 percent of the nonfederal share to be financed by local governments. This requirement is applied on the basis of total annual Medicaid program spending and not on individual payments or types of payments.

In addition to flexibility in determining sources of funds to use to finance their nonfederal share, states have flexibility, within broad federal requirements, in designing and operating their Medicaid programs, including determining services to cover and setting payment rates for providers. In general, federal law provides for federal matching funds for state Medicaid payments for covered services provided to eligible beneficiaries up to a ceiling or limit, often called the upper payment limit (UPL).[11] The UPL is based on what Medicare would pay for the same

[10]The FMAP is based on a formula established by law under which the federal share of a state's Medicaid expenditures for services generally may range from 50 to 83 percent. States with lower per capita income receive a higher FMAP for services.

[11]The UPL is not applied to payments to individual providers and instead applies to payments to all providers rendering specific services within an ownership class, such as state government-owned or -operated hospital's payments for inpatient services. UPL's exist for inpatient hospital services provided by hospitals, nursing facilities, and intermediate care facilities for individuals with intellectual disabilities, and for outpatient services provided by hospitals' and clinics.

services. Typically, state Medicaid payment rates are lower than what the Medicare program would pay, and so many states make supplemental payments under the UPL. Unlike regular Medicaid payments, which are generally based on claims submitted by providers for services rendered, supplemental payments often consist of large, lump sum payments made on a monthly, quarterly, or yearly basis and can be targeted to small groups of providers, such as local government hospitals. Supplemental payments totaled at least $43 billion in federal fiscal year 2011, including $26 billion made under the UPL, but reporting was incomplete. Supplemental payments have been growing in size, as they totaled at least $23 billion in federal fiscal year 2006.

Our prior work has raised concerns about gaps in the oversight of supplemental payments made under the UPL.[12] As part of its oversight responsibilities, CMS is responsible for ensuring that state Medicaid payments are consistent with federal requirements, including that Medicaid payments are economical and efficient. In recent years, we have found several instances of payments that raise concerns about compliance with these requirements. For example, in November 2012, we reported that 39 states had made supplemental payments to 505 hospitals that, along with their regular Medicaid payments, exceeded those hospitals' total costs of providing Medicaid care by $2.7 billion. Although Medicaid payments are not required to be limited to a provider's costs of delivering Medicaid services, payments that greatly exceed these costs raise questions; for example, as to whether payments are being used for allowable Medicaid expenditures.[13] We have previously made recommendations to CMS—including recommendations to require states to report the amounts of UPL supplemental payments that they make to individual providers—to review all state supplemental payment programs, and enhance the oversight of payments made to government providers.[14] CMS has not implemented all of these recommendations. We have also

[12]See the list of Related Products at the end of this statement.

[13]See GAO-13-48.

[14]See GAO, *Medicaid: Improved Federal Oversight of State Financing Schemes Is Needed*, GAO-04-228 (Washington, D.C.: Feb. 13, 2004), *Medicaid Financing: States' Use of Contingency-Fee Consultants to Maximize Federal Reimbursements Highlights Need for Improved Federal Oversight*, GAO-05-748 (Washington, D.C.: June 28, 2005) and *Medicaid: CMS Needs More Information on the Billions of Dollars Spent on Supplemental Payments*, GAO-08-614 (Washington, D.C.: May 30, 2008).

suggested that the Congress consider requiring CMS to require states to submit annual independent audits of supplemental payments made under the UPL, which are not currently subject to audit.[15]

CMS uses a range of tools to oversee state Medicaid payments, including review and approval of states' Medicaid plans and amendments. State plans describe, among other things, who and how much states will pay for particular services. For any new payment or payment change, a state must submit a state plan amendment, for which CMS asks the state to provide

- information and data showing that state Medicaid provider payments (regular and supplemental payments combined) do not exceed the UPL for the category of service and type of provider ownership; and
- a written response to a set of standard questions intended to gauge the appropriateness of state payments and financing. For example, CMS asks states during this process if the payment change will result in any government provider receiving payments that exceed the provider's reasonable costs of providing Medicaid services.

CMS also tracks and reviews states' total Medicaid expenditures on a quarterly basis. States seek federal matching funds by submitting aggregated spending amounts for broad categories of services on a standard form known as the CMS-64.

[15]See GAO-13-48.

States' Reliance on Funds from Providers and Local Governments to Finance Medicaid Has Increased in Recent Years, with Implications for Federal Costs

States Used Funds from Providers and Local Governments to Finance over $46 Billion, or 26 Percent, of the Nonfederal Share of Payments in 2012, an Increase from 2008

In the report that is being released today, we found that states used funds from health care providers and local governments to finance 26 percent, or over $46 billion, of the $180 billion in the total nonfederal share of Medicaid payments—both regular and supplemental—in state fiscal year 2012.[16] Of the total amount of funds from health care providers and local governments, taxes on providers were the largest single source of funds, followed by transfers of funds from local governments. Of the over $46 billion, states received $18.8 billion from health care provider taxes and $18.1 billion from transfers of funds from local governments.[17]

States' reliance on funds from health care providers and local governments to finance the nonfederal share of Medicaid payments increased by over 21 percent from state fiscal years 2008 through 2012, in large part due to increases in revenues from health care provider taxes. Specifically, the percentage of funds from health care providers and local

[16]See GAO, *Medicaid Financing: States' Increased Reliance on Funds from Health Care Providers and Local Governments Warrants Improved CMS Data Collection*, GAO-14-627 (Washington, D.C.: July 29, 2014).

[17]State general funds supplied $113.2 billion of the nonfederal share of Medicaid in state fiscal year 2012, and intra-agency funds supplied $11.9 billion. Intra-agency funds include contributions from other state agencies, such as state departments of mental health, that pay Medicaid providers, for example, through an intra-agency agreement; a transfer of funds to the state Medicaid agency from a state government entity that has been appropriated state general funds; or a certification of expenditures for Medicaid-covered services provided to a Medicaid beneficiary from a state government entity that has been appropriated state general funds.

governments that states used to finance the nonfederal share increased from 21 percent to 26 percent during this 5-year period, for an increase of 5 percentage points, or 21 percent. While the total amount of funds from all sources, including state funds,[18] increased during this period, funds from providers and local governments increased as a percentage of the nonfederal share, while the percentage of state funds decreased. Health care provider taxes represented the source of funds from health care providers and local governments with the largest increase, $9 billion, during the 5-year time period. We found that a total of 85 new provider taxes were implemented in 32 states during this time period.

Our analysis shows that for supplemental payments alone, the percentage of the nonfederal share that states financed with funds from health care providers and local governments was relatively high, and increasing. In particular, the percentage of the nonfederal share of supplemental payments that was financed with funds from providers and local governments increased from 57 percent in 2008 to 70 percent in 2012. In other words, almost three-quarters of the nonfederal share of supplemental payments was financed by providers, and not state funds. These large payments that states can target to small groups of providers without linking them to services provided were, to a much greater extent than regular Medicaid payments, financed by the providers.[19]

In the report we are releasing today, we also found that CMS does not collect complete and accurate data on state Medicaid financing methods. States are required, under federal law, to report the amounts of funds from provider taxes and donations used to finance the nonfederal share, but CMS has not ensured that this data is complete and accurate. Reporting of funds from local government providers and local governments that are used by states to finance the nonfederal share of Medicaid is not required under federal law. CMS may seek on a case-

[18]For purposes of this statement state funds refer to state general funds and intra-agency funds.

[19]The percentages for supplemental payments were significantly higher than the percentages for regular payments in each year from state fiscal year 2008 through 2012. For example, in 2012 providers supplied 74 percent (or $9.2 billion) of the nonfederal share of the largest type of supplemental payments, compared to 23 percent (or $25.8 billion) of regular payments. Federal law requires that no more than 60 percent of the nonfederal share is financed by local governments. However, this requirement is applied on the basis of total annual Medicaid program spending and not on individual payments or types of payments.

specific basis information on financing arrangements when reviewing individual state plan amendments; however, the information provided varies by state, and CMS officials reported that states are not required to identify the amount of funds provided by or on behalf of any specific providers or the amount of payments made to providers. Without accurate and complete information on state sources of funds, we concluded that CMS is unable to adequately understand and oversee Medicaid financing and payments, including net payments, to individual providers. In the report we are releasing today, we recommend that CMS take steps to ensure states report accurate and complete information on all sources of funds used to finance the nonfederal share. CMS did not agree with our recommendation and stated that the agency's current data collection processes are sufficient, and at this time more detailed reporting is not needed.

Changes in Financing Arrangements in Selected States Illustrate How the Arrangements Can Shift Medicaid Costs to the Federal Government

In the report being released today, we present information on recent changes in financing arrangements involving funds from providers and local governments in three selected states that illustrates how such changes can shift Medicaid costs from the state to the federal government. In effect, states seeking to raise payment rates to providers can finance those increased rates by asking providers to provide the funds to finance the state share of the payment, and then seek federal matching on the larger amount. By increasing providers' Medicaid payments, and at the same time imposing requirements on providers receiving the payments to supply all or most of the nonfederal share for the payments, states could obtain additional federal matching funds for those facilities' payments without a commensurate increase in state general funds. The use of funds from providers and local governments is, as previously described, allowable under federal rules, but it can also have implications for federal costs. And from the providers' perspective, the use of funds from providers to finance an increase in Medicaid payments results in a net payment to the provider that is less than the amount used for purposes of claiming federal funds.

In three selected states, we reviewed a financing arrangement that involved financing the nonfederal share of new Medicaid payments with funds from provider taxes or transfers of funds from local governments put in place in recent years. For these arrangements, we estimated the effect on the federal and state shares of new payments the state was making. In each case, we determined that the result was a net increase in payments to the providers—after accounting for both the payment increase they received, as well as the increased funds they or a local

government provided to the state to finance the nonfederal share of the payments—and increases in costs to the federal government. The state contribution to the new Medicaid payments, in each case, did not increase compared to what it would have been had the new financing arrangement not taken place. For example, one state increased regular Medicaid payments for nursing facilities in May 2011, and financed these payments with a provider tax on nursing facilities. According to our estimates, the increased regular Medicaid payment and new provider tax had the effect of increasing federal matching payments by $110 million. The overall net increase in provider payments—that is, the increase in total Medicaid payments ($220 million) minus the total cost of the new provider tax ($115 million)—was $105 million. The state supplied $5 million less in state general funds than it would have paid had the increased payment and new provider tax not gone into effect.[20]

[20]As part of our analysis, we estimated the amount of regular Medicaid payments to providers, provider taxes collected, and the state and federal share of Medicaid payments had the increases in provider taxes and Medicaid payments not taken place.

Preliminary Results Suggest That Data Needed to Oversee Medicaid Payments to Government and Private Providers Are Lacking

Our ongoing work has identified two major gaps in federal data necessary for overseeing Medicaid payments. First, neither of the two major sets of data that CMS has available for oversight captures the ownership status—government or private—of individual providers.[21] Second, federal data on state Medicaid payments generally capture regular payments for services rendered by individual providers, but generally do not capture states' lump sum supplemental payments to individual providers.[22] We have previously reported that data on the providers receiving supplemental payments, and the amounts paid to particular providers, are maintained by the state making the payments.[23] States generally do not submit these payments to CMS for inclusion in its automated claim data system, which captures regular payments made to individual providers. Without provider-specific payment data that includes supplemental payments, CMS does not have a complete picture of how the $43 billion in supplemental payments mentioned above in this statement was allocated among the individual government or private providers. As a result of these two gaps in the federal data on state Medicaid payments, CMS is not able to assess payments to government providers compared to private providers, and cannot detect any outlier provider payments, such as providers receiving significantly larger amounts in Medicaid payments than other providers providing similar services. This lack of data also limits CMS's ability to ensure that payments to individual providers are economical and efficient.

[21]CMS has two data sets available for overseeing Medicaid payments, but each data set has a different purpose and neither one provides the data needed for effective oversight. Neither of these data sets provides CMS with the data needed to effectively monitor states' Medicaid payments to government providers. The Medicaid Statistical Information System (MSIS) is a national eligibility and claims data set and is the federal source of Medicaid expenditure data that can be linked to a specific enrollee and provider. The CMS-64 data set aggregates states' Medicaid expenditures by broad expenditure categories, and is used by CMS to reimburse the states for the federal share of Medicaid expenditures. States are required to provide CMS with MSIS and CMS-64 expenditure data quarterly. 42 C.F.R. § 430.30(b), (c).

[22]Once states receive approval to make a particular supplemental payment under their state plan, they are allowed to make these payments outside of CMS's automated claims system.

[23]See GAO, *High-Risk Series: An Update*, GAO-13-283 (Washington, D.C.: February 2013), *Medicaid: Data Sets Provide Inconsistent Picture of Expenditures*, GAO-13-47 (Washington, D.C.: Oct. 29, 2012).

At the state level, our ongoing work has found that the state payment data needed to understand provider-specific payments can be challenging to obtain and assess, and are not always reliable. We have sought to obtain payment data on supplemental payments, by ownership, from three selected states to combine with federal data on regular Medicaid payments so that we could assess how total Medicaid payments to government providers compare to payments to private providers. Doing this work, however, has proved to be difficult, illustrating the challenge in overseeing Medicaid payments and ensuring that payments to individual providers are economical and efficient. In each of the three states, we encountered obstacles in capturing complete information on payments and provider ownership. For example, states may

- use multiple provider identification numbers for the same provider;
- use a different provider identification number for supplemental payments versus regular payments, complicating the process of combining data sets to understand full payments to individual providers;[24] and
- be unable to report provider ownership by state government, local government, and private.

Our ongoing effort to compile reliable and accurate provider-specific ownership and supplemental payment data has been, and continues to be, a time consuming and labor intensive effort as a result of data obstacles. We have encountered issues with data in all three states. For one of the three states, we have determined that data issues are of such difficulty that they preclude completing an assessment. The state was not able to provide us with data that were sufficiently reliable to allow us to identify Medicaid payments by provider ownership.[25]

[24]Providers are assigned a unique identification number so that they can be separately identified from other providers; however, this does not necessarily result in each provider only having one unique identification number. State Medicaid programs have multiple divisions and programs that interact with providers, and each of these may have a different data processing system for tracking provider information and use a different provider identification number.

[25]Our ongoing work is examining payments for four categories of Medicaid services: Inpatient Hospital Services, Outpatient Hospital Services, Nursing Facility Services, and Intermediate Care Facilities for the developmentally disabled in two states. For these services we are comparing payments for three types of ownership: state government, local government, and private.

In one state for which we have determined that data were sufficiently reliable to report today, our preliminary analysis of the state's payments for inpatient hospitals in state fiscal year 2011 suggests the need for and value of having complete data to analyze Medicaid payments by provider ownership.[26] For this state, we were able to combine the state-provided supplemental payments made under the UPL and provider ownership data with the federal claims data on regular payments and Medicaid patient days.[27] Although our work analyzing this state's data to examine payments for different types of services to different types of providers is ongoing, we have completed the preliminary analysis for one type of service: inpatient hospital payments. With these data, we have determined each hospital's daily payment amount by dividing total Medicaid payments for each hospital by the hospital's total Medicaid patient days. We then calculated the average daily payment amounts for three categories of provider ownership: state government, local government, and private. Where possible, our preliminary analysis adjusted regular payments for differences in the conditions of the patients treated by the hospitals, commonly referred to as "case mix" adjustments.[28] Our preliminary analysis shows that

- For the regular payments, state government hospitals had the highest average daily payment amount, at about $1,140, which was 19 percent higher than the average for local government hospitals ($940) and 29 percent higher than the average for private hospitals ($860).
- When the state's supplemental payments were factored in, local government hospitals replaced state government hospitals as receiving the highest average, and the gap between the local government hospitals' and private hospitals' averages increased further. Local government hospitals' average daily payment amount

[26]For purposes of this analysis, we excluded state government mental health hospitals.

[27]For purposes of this analysis, we did not include disproportionate share hospital (DSH) supplemental payments—Medicaid supplemental payments that states are required by federal law to make to hospitals that serve large numbers of Medicaid and low-income individuals.

[28]We case mix adjusted regular payments for all hospitals for which case mix information was provided—about 84 percent of the state's hospitals. These hospitals' regular payments are based on a prospective payment system—a predetermined payment amount—under which each hospital's payment amount is adjusted to reflect the differences in the conditions of the patients treated by the hospital.

was about $1,470, which was 25 percent higher than the average for state government hospitals ($1,140) and 44 percent higher than for private hospitals ($930).

Our preliminary analysis also shows that, because the state was targeting its UPL supplemental payments to only two local government hospitals, the higher payments to these hospitals accounted for much of the differences in average daily payment amounts when UPL supplemental payments were included in the average. Together these hospitals received nearly $416 million in UPL supplemental payments, compared to $70 million in regular Medicaid payments. Our preliminary analysis of the average daily payment amounts for regular and UPL supplemental payments for these two hospitals suggests that the average amount at one hospital was as high as about $8,800 per day, significantly higher than the approximately $1,470 average amount for all local government hospitals.[29] The other hospital had a lower average, although it was still higher than the average for private hospitals. According to the state's Medicaid officials, these hospitals served higher needs patients.

Our preliminary examination of key documentation around CMS's review of the provisions authorizing the state's supplemental payments to these two local government hospitals shows that CMS's documentation did not identify the large supplemental payments the two hospitals received. We reviewed the state plan amendment authorizing the supplemental payment, the funding questions that CMS asked when the state submitted a proposed change to the payment, and the annual report the state submitted to CMS in 2011 regarding the state's estimated UPL for local government hospitals. Our preliminary observations when reviewing this documentation were that

- The state plan amendment approved by CMS in June 2011 authorized the state to make over $400 million in supplemental payments proportionally to all local government hospitals eligible for a

[29]For purposes of comparing this hospital's average daily payment to the average daily payment amounts for the three ownership types, we adjusted this hospital's regular Medicaid payments using the state's highest hospital case mix adjustment factor. We did this because case mix information was not available for this hospital, and by using the state's highest case mix adjustment it provides for the maximum possible adjustment. If we did not case mix adjust the hospital's regular payment amount, we estimated that with regular and UPL supplemental payments the hospital's average daily payment amount was about $9,180.

payment under the state plan amendment. The state plan amendment, however, did not specify the number or names of hospitals that were eligible based on somewhat ambiguous eligibility criteria including that they be located in a city of a certain size and having received a certain amount of medical assistance payments.[30]

- When the state proposed to increase the supplemental payment amount through a state plan amendment, CMS followed its process for requesting new information on the payments—in particular, whether any payments to governmental providers would exceed the providers' reasonable costs of providing services. However, the state's written response did not indicate whether any providers would be paid above their costs and instead stated that it was "unaware of any requirement under current federal law or regulation that limits individual provider payments to their actual costs."
- Information provided by the state under CMS's requirement that states submit information showing that state payments would not exceed the UPL did not contain information on the actual payments individual hospitals received.[31] As requested by CMS, the state submitted information on the methodology for estimating each hospital's UPL, but did not submit actual UPL payment information that would have shown that the state was making all of the supplemental payments to only two hospitals. The state's estimate of what Medicare would have paid the hospitals for the Medicaid services provided was about $100 million, compared to the $416 million those two facilities received.[32] Since the UPL is applied across a class of facilities, in this case local government hospitals,

[30]The following state plan provision identifies the eligibility criteria for hospitals to receive supplemental payments: payments "...are authorized to government general hospitals, other than those operated..." by the state or the state university hospital "...receiving reimbursement for all inpatient services under Title XIX of the federal Social Security Act (Medicaid) pursuant to this Attachment of this State Plan and located in a city with a population of over one million, of up to $286 million annually, as medical assistance payments." Further, the state plan provisions for determining which providers receive payments and how much they will receive, states that payments "...shall be based on each such hospital's proportionate share of the sum of all inpatient discharges for all facilities eligible for an adjustment pursuant to this section for the base year two years prior to the rate year."

[31]In June 2013, CMS began requiring states to submit information and data annually to demonstrate that hospital payments do not exceed the UPL, an action that was previously required only when a state proposed a change in payments.

[32]The $100 million is the state's estimated UPL for the two hospitals.

and not for individual facilities or hospitals, the state was able to direct all supplemental payments available for all 21 local government hospitals under the UPL to the two local government hospitals.

In reviewing information on the state's payments to the two hospitals, our preliminary analysis found that the state did not contribute any state general funds to finance the nonfederal share of the two hospitals' supplemental payments, as the nonfederal share of the payments was financed by a local government that operated the two hospitals. This illustrates prior concerns we have raised about the incentives to overpay certain government providers, including those for which the state is not providing funds to finance the nonfederal share.[33]

In discussing the circumstances around these two hospitals payments and payment amounts, CMS officials reported that they review the total amount of UPL supplemental payments for local government hospitals as a group, and not payments to individual hospitals. We will continue to complete our ongoing work and will issue a final report later this year including any suggested actions needed by CMS, as appropriate.

In conclusion, our report that is being released today on how states are financing the nonfederal share of Medicaid, and our ongoing work on Medicaid payments to government providers, demonstrate the importance and need for effective federal oversight. CMS has taken important steps over the years to enhance its oversight, including requiring annual demonstrations of state UPL estimates. We believe even more can be done to improve the transparency of Medicaid financing and payments, including previous recommendations that have not been implemented, such as facility specific reporting of supplemental payments and review of all state supplemental payment programs, and the recommendation from the report we are issuing today that CMS take steps to ensure states report accurate and complete data on all sources of funds to finance the nonfederal share.

[33]See GAO, *Medicaid Financing: States' Use of Contingency-Fee Consultants to Maximize Federal Reimbursements Highlights Need for Improved Federal Oversight*, GAO-05-748 (Washington, D.C.: June 28, 2005).

Chairman Lankford, Ranking Member Speier, and Members of the Subcommittee, this concludes my prepared statement. I would be pleased to respond to any questions you may have.

GAO Contacts and Staff Acknowledgments

If you or your staff have any questions about this testimony, please contact me at (202) 512-7114 or iritanik@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement. Tim Bushfield, Assistant Director; Elizabeth Conklin; Julianne Flowers; Sandra George; Peter Mangano; and Roseanne Price were key contributors to this statement.

Appendix I: Abbreviations

CMS	Centers for Medicare & Medicaid Services
FMAP	Federal Medical Assistance Percentage
HCFA	Health Care Financing Administration
ICF/DD	intermediate care facilities for the developmentally disabled
MSIS	Medicaid Statistical Information System
UPL	upper payment limit

Mr. LANKFORD. Thank you.
Mr. Hagg?

STATEMENT OF JOHN HAGG

Mr. HAGG. Good morning, Mr. Chairman and other distinguished members of the committee.

Thank you for the opportunity to testify about the Office of Inspector General's efforts to identify improper state claims of federal Medicaid dollars.

Per your request, my testimony summarizes OIG reports in select areas of the New York Medicaid Program. The two key takeaways from my testimony are: one, New York must do a better job of monitoring providers to ensure that only allowable services are paid and two, CMS must be vigilant in overseeing the states to ensure that states do not claim federal reimbursement for improper payments.

The New York Medicaid Program is one of the largest in the Country. In fiscal year 2013, New York received more than $26 billion in federal reimbursements. It had over 5 million beneficiaries enrolled.

With such significant dollars and a sizable beneficiary population at risk, it is critical that New York vigorously oversee providers and other components of its Medicaid Program. OIG has found millions in improper payments including payments for services not provided and duplicate payments.

Based on our reviews, New York should: one, refund the federal share of overpayments to the Federal Government. Overpayments in the reports referenced in my testimony amounted to more than $200 million.

Two, New York should issue better guidance to the provider community regarding federal and state requirements for claiming Medicaid reimbursement.

Three, New York must improve monitoring to help ensure that providers are in compliance with applicable federal and state rules.

States alone do not have sole responsibility in overseeing the Medicaid Program. Our work has uncovered significant problems when states game the system and CMS does not act quickly to stop it.

My prior testimony before this committee discussed payments to state-run developmental centers, payments that far exceeded the cost of providing services. If New York had used actual costs in its rate setting methodology, it would have paid $1.4 billion less for services in 2009. This would have saved the Federal Government as much as $700 million in that year alone.

These rates escalated drastically over time because the state's rate-setting methodology originally approved by CMS in 1986 significantly inflated the Medicaid daily rate for developmental centers and CMS did not prevent the rate from increasing to its current levels.

We have identified similarly inflated payments to New York State-run residential facilities. These facilities provide habilitation services which assist individuals in obtaining skills to live in the community. If New York had used actual costs in its rate setting

methodology, it would have saved the Federal Government as much as $346 million in 2011 alone.

In April 2013, CMS and New York agreed on a new methodology for determining rates paid to state-operated developmental centers that will better align rates and costs. CMS needs to do the same with the state-operated facilities that provide habilitation services to ensure that this methodology meets the federal requirements that payments be consistent with efficiency and economy.

These needs are not specific to New York. While my testimony today focuses on select issues in the New York Medicaid Program, OIG's audits in other states reveal similar problems with both state and CMS oversight.

Given the projected growth in Medicaid, it is critical that we promote integrity, accountability and policies to better protect Medicaid resources.

Thank you for your interest in this important issue. I appreciate the opportunity to appear before you today. I would be happy to answer your questions.

[Prepared statement of Mr. Hagg follows:]

Testimony of:
John Hagg
Director of Medicaid Audits
Office of Inspector General
U.S. Department of Health and Human Services
Hearing Title: "Examining the Federal Government's Failure to Curb Wasteful State Medicaid Financing Schemes"
House Committee on Oversight and Government Reform
Subcommittee on Energy Policy, Health Care and Entitlements

Good morning, Chairman Lankford, Ranking Member Speier, and other distinguished Members of the Committee. Thank you for the opportunity to testify about the Office of Inspector General's (OIG) ongoing efforts to identify improper State claims of Federal Medicaid dollars. Federal and State outlays for Medicaid exceed $450 billion and are increasing as the beneficiary population expands. OIG has conducted a wide range of State- and national-level Medicaid reviews and has identified protecting the integrity of an expanding Medicaid program as a top management challenge for the Department of Health and Human Services (HHS).[1]

Per your request, my testimony summarizes select OIG reports in four areas of the New York Medicaid program — provider types that are susceptible to fraud, waste, and abuse; Medicaid payments to managed care organizations; payment rates for State-operated facilities; and other areas or issues that OIG determined to be vulnerable to inappropriate claims.

The two key takeaways from my testimony are:

- New York must do a better job of monitoring providers to ensure that only allowable services are paid. Improper payments cost taxpayers and beneficiaries billions of dollars a year. For example, in 2013, the Department reported an improper Medicaid payment rate of 5.8 percent, or $14.4 billion (in Federal payments). Greater monitoring of providers by States protects both State and Federal dollars from being misspent.
- The Centers for Medicare & Medicaid Services (CMS) must take more aggressive action to ensure that States do not improperly claim Federal reimbursement for payments to which they are not entitled. In the past, we have seen States inappropriately maximize their payments from the Federal Government. When this happens, CMS must stop these occurrences and correct them.

New York Must Improve Oversight of Its Medicaid Program

The New York Medicaid program is the second largest in the country. In fiscal year 2013, New York received more than $26 billion in Federal reimbursement and had over 5 million

[1] See *Top Management and Performance Challenges*, available at http://oig.hhs.gov/reports-and-publications/top-challenges/2013/challenge04.asp.

beneficiaries enrolled in its Medicaid program. In areas such as home health services, continuing day treatment (CDT) services, orthodontic and dental services, and traumatic brain injury waiver services, OIG has found millions in improper payments, including payments for services that were not provided and duplicative payments. With such significant dollars and a sizeable beneficiary population at risk, it is critical that New York vigorously oversee providers and other components of its Medicaid program.

Home Health Services Did Not Meet State and Federal Requirements

Home health services are services provided to beneficiaries who need additional support to remain safely at home and avoid unnecessary hospitalization. Our audit of home health services in New York identified some claims for services that were not provided in accordance with Federal and State requirements.[2] These requirements include: the beneficiary must have a plan of care that the physician reviews every 60 days, services must be documented, services must be furnished in the beneficiary's place of residence, and aides must meet certain training requirements. These requirements are in place to ensure that patients receive appropriate care in an appropriate setting. Most of the claims we examined met Federal and State requirements, but New York claimed Federal reimbursement of at least $31 million over 3 years for services that did not. Most of the noncompliant claims did not meet the requirement that the physician review the beneficiary's plan of care within the prescribed time frame. New York paid for and billed the Federal Government for noncompliant services because it had not ensured that Certified Home Health Agencies were familiar with requirements related to physician orders and plans of care.

Continuing Day Treatment Services Did Not Meet State and Federal Requirements

CDT services are individually tailored treatment services for individuals with mental illness that address substantial skill deficits in specific life areas that interfere with an individual's ability to maintain community living. CDT services include assessment and treatment planning, discharge planning, medication therapy, case management, psychiatric rehabilitation, and activity therapy, among others. Our audits of CDT services in New York found that the State claimed reimbursement of at least $26.1 million over a 2.5-year period for services (provided by hospital-based and non-hospital-based providers) that did not meet certain Federal and State requirements.[3] These requirements include: progress notes for each beneficiary must be recorded at least every 2 weeks by the clinical staff members who provided the CDT services, the provider must document a minimum visit of at least 2 hours, the treatment plan should include specified elements, and the treatment plan must be reviewed periodically and should be signed by the physician involved in the treatment and the beneficiary (if appropriate). Most of

[2] *New York State Improperly Claimed Medicaid Reimbursement for Some Home Health Services Claims Submitted by Certified Home Health Agencies,* A-02-11-01008, September 2013, available at http://oig.hhs.gov/oas/reports/region2/21101008.asp.

[3] *New York Claimed Hospital-Based Continuing Day Treatment Services That Were Not in Compliance With Federal and State Requirements*, A-02-11-01038, September 2013, available at http://oig.hhs.gov/oas/reports/region2/21101038.asp, and *New York Claimed Nonhospital Continuing Day Treatment Services That Were Not in Accordance With Federal and State Requirements*, A-02-12-01011, July 2014, available at http://oig.hhs.gov/oas/reports/region2/21201011.asp.

the noncompliant claims we identified fell into one or more of the following four categories: (1) progress notes associated with the services were not recorded as required, (2) minimum visit requirements for reimbursement were not met, (3) the beneficiary's treatment plan was not complete, and/or (4) the beneficiary's treatment plan was not signed by either the beneficiary or physician. New York paid and claimed Federal reimbursement for noncompliant services because: (1) certain hospital-based CDT providers did not comply with Federal and State requirements and (2) the State agency did not ensure that the New York State Office of Mental Health adequately monitored the CDT program for compliance with certain Federal and State requirements.

Questionable Billing for Orthodontic and Dental Services

The New York State Medicaid Orthodontic Program provides orthodontic services to beneficiaries with "severe handicapping malocclusions." This type of malocclusion occurs when a child's teeth are so far out of position that he or she cannot engage in normal activities — such as eating and talking — without difficulty.

Our audit of orthodontic services in New York City found that the State claimed reimbursement of at least $7.7 million over 3 years for services that did not meet certain Federal and State requirements.[4] These requirements include: eligibility for orthodontic care must be reevaluated annually, services must be documented, and services must be provided to eligible beneficiaries by certified providers. The unallowable services all fell into one or more of the following categories: (1) services were not authorized, (2) providers could not document that services had been provided, or (3) services were not provided. New York paid for and claimed Federal reimbursement for noncompliant services because providers did not follow requirements.

In a separate evaluation of orthodontic and dental services in New York, we examined the billing patterns of general dentists and orthodontists who provided services to 50 or more Medicaid children during 2012.[5] We identified 23 general dentists and 6 orthodontists whose billing patterns, when compared with those of their peers, were questionable. Questionable billing patterns included extremely high payments per child, an extremely large number of services per child, a large number of services per day, and extractions and pulpotomies—often referred to as "baby root canals"—on an extremely high proportion of children.

Traumatic Brain Injury Waiver Services Did Not Meet State and Federal Requirements

Traumatic brain injury waiver services are a set of services provided to help beneficiaries with traumatic brain injuries to live in community-based settings and achieve maximum independence. New York's Traumatic Brain Injury Program is part of its larger strategy to prevent unnecessary entrances into nursing homes and to help individuals leave nursing homes.

[4] *New York Improperly Claimed Medicaid Reimbursement for Orthodontic Services to Beneficiaries in New York City,* A-02-11-01003, October 2013, available at http://oig.hhs.gov/oas/reports/region2/21101003.asp.
[5] *Questionable Billing for Medicaid Pediatric Dental Services in New York*, OEI-02-12-00330, March 2014, available at https://oig.hhs.gov/oei/reports/oei-02-12-00330.asp.

Our audit of traumatic brain injury waiver services in New York found that the State claimed reimbursement of at least $54 million over 3 years for services that did not meet certain Federal and State requirements.[6] These requirements include: beneficiaries must be assessed to need nursing facility level of care, services must be documented, and services must be provided in accordance with an approved plan of care. Most of the noncompliant claims we identified were for services provided to individuals who did not qualify to receive waiver services. In addition, many of the noncompliant services were not adequately documented or were not provided in accordance with the beneficiaries' required plans of care.

We found that New York paid for and claimed Federal reimbursement for noncompliant services because it did not ensure that: (1) centers responsible for administering the program properly determined and documented that beneficiaries approved for the program were eligible, (2) assessors and screeners responsible for determining eligibility properly evaluated beneficiaries, and/or (3) providers billed the State only for allowable program services.

Fee-for-Service Payments for Services to Beneficiaries Enrolled in Medicaid Managed Care

Our audit of fee-for-service payments on behalf of beneficiaries enrolled in Medicaid managed care plans found that New York claimed Federal reimbursement of $23.4 million for unallowable fee-for-service payments over approximately 5 years.[7] Although the services may have otherwise met Federal and State requirements, these services should have been paid for by the beneficiaries' Medicaid managed care plans; therefore, the fee-for-service payments were duplicate payments. New York paid and claimed reimbursement for unallowable fee-for-service claims because it operated two eligibility systems; as a result, some beneficiaries received multiple Medicaid numbers.

CMS Should Exercise Greater Oversight of States' Activities To Obtain Inappropriate Federal Reimbursement

The Federal Government and States share the cost of Medicaid. From time to time, States have adopted practices that have artificially inflated the Federal Government's share of Medicaid expenditures. Such practices limit Congress's ability to assess the public benefits of Medicaid dollars. OIG addressed this issue broadly in an audit in 2001, and since then, we have continued to identify similar problems in selected States.

Excessive Rates for Services Provided by State-Run Facilities

OIG's September 2012 testimony before this Committee focused on an OIG report that identified payments to New York State-run developmental centers that far exceeded the cost of providing

[6] *New York's Claims for Medicaid Services Provided Under Its Traumatic Brain Injury Waiver Program Did Not Comply With Certain Federal and State Requirements,* A-02-10-0143, May 2013, available at http://oig.hhs.gov/oas/reports/region2/21001043.asp.

[7] *New York State Made Unallowable Medicaid Fee-for-Service Payments for Beneficiaries Also Enrolled in Medicaid Managed Care,* A-02-12-01007, January 2014, available at http://oig.hhs.gov/oas/reports/region2/21201007.asp.

services.[8] In that report, we noted that if New York had used actual costs in its rate-setting methodology, it would have paid $1.4 billion less for services in 2009, which would have saved the Federal Government as much as $701 million in that year alone.[9] In March 2014, we issued a report that identified similarly inflated payments to State-run residential facilities that provide habilitation services.[10] In that report, we determined that if the State agency had used the prior year's actual costs to calculate payment rates for residential habilitation services, its State fiscal year 2011 total reimbursement would have been approximately $692 million less than what it claimed, which would have saved the Federal Government as much as $346 million in that year.

In both instances, we found that the methodologies New York used to develop the rates charged by the State-run facilities resulted in payments that greatly exceeded the costs of the programs. In both instances, the gap between the rates used to reimburse facilities and the actual costs of providing those services increased over many years. CMS, however, did not take action to prevent the gap between reimbursement and costs from growing to the extent that it did until early last year. Last year, CMS and New York agreed on a new methodology for determining the rates paid to State-run developmental centers that will better align rates and costs. This methodology became effective in April 2013.

Unallowable Costs Used To Calculate Payment Rates

Medicaid does not generally pay for room-and-board costs incurred by community residential facilities under a State's home and community-based services Medicaid waiver program. Our audit of the rates paid to State-operated community residential facilities for habilitation services provided to individuals with developmental disabilities found that that New York claimed excessive Federal reimbursement of $60.8 million over 3 years because some room-and-board costs were included in the indirect costs used to calculate the rates.[11] The unallowable room-and-board costs included repairs, maintenance, utilities, and property-related costs.

The rates were inflated because the New York Medicaid agency determined that it could include the portion of certain room-and-board costs (repairs, maintenance, utilities, and property-related costs) related to what it characterized as the non-residence-related square footage in the indirect cost rate used to calculate payment rates. However, New York characterized these costs as "additional residential habilitation costs" and they were not readily identifiable as room-and-board costs.

[8] Available at http://oig.hhs.gov/testimony/docs/2012/Hagg_testimony_09202012.pdf.
[9] *Medicaid Rates for New York State-Operated Developmental Centers May Be Excessive,* A-02-11-01029, May 2012, available at http://oig.hhs.gov/oas/reports/region2/21101029.asp.
[10] *Medicaid Rates for Residential Habilitation Services Provided at New York State-Operated Residences Are Excessive*, A-02-13-01008, March 2014, available at http://oig.hhs.gov/oas/reports/region2/21301008.asp.
[11] *New York Claimed Unallowable Room-and-Board Costs Under Its Developmental Disabilities Waiver Program*, A-02-12-01031, May 2014, available at http://oig.hhs.gov/oas/reports/region2/21201031.asp.

Key Recommendations

Key recommendations from the reports I have discussed today include recommendations to both the New York Medicaid State agency and to CMS.

The State agency should:

- Refund the Federal share of the overpayments to the Federal Government. Overpayments in these reports amounted to more than $200 million.
- Issue guidance to the provider community regarding Federal and State requirements for claiming Medicaid reimbursement.
- Improve monitoring to help ensure that providers are in compliance with applicable Federal and State rules.

CMS should:

- Work with New York to help ensure that the methodology used to set payment rates for State-operated facilities meet the Federal requirements that payments for services be consistent with efficiency and economy.

These recommendations address two important needs: for States to improve their oversight of Medicaid providers and for CMS to improve its oversight of States to detect and prevent efforts to inappropriately shift costs to the Federal Government. These needs are not specific to New York. While my testimony today focuses on select issues in the New York Medicaid program, OIG's reviews of Medicaid in other States reveal similar problems with both State and CMS oversight.

Conclusion

New and changing HHS programs, such as Medicaid and others, offer opportunities to improve health and welfare, prevent waste and fraud, and increase the value realized from Federal investments. They also raise challenges for efficient and effective implementation; therefore, close oversight is essential. With respect to oversight of Medicaid, OIG has a substantial body of work both underway and planned to ensure that taxpayer dollars are spent for their intended purposes in a system that operates efficiently and is secure. This work will examine critical issues, such as Medicaid provisions included in the Affordable Care Act, Medicaid payments for medical equipment and supplies, health care provider taxes, and Medicaid payments to managed care organizations.

Funding of OIG's fiscal year 2015 budget request would enable us to continue and enhance our focus on core risk areas associated with Medicaid, as well as HHS public health and human

service programs, the marketplaces, and Medicare.[12] Given the projected growth in Medicaid by CMS, the Congressional Budget Office, and others, we have a responsibility to promote integrity, accountability, and potential cost savings in Medicaid through reports that recommend recoupment of overpayments, changes to policies to better protect Medicaid resources, and improvements that lead to better quality of care for Medicaid beneficiaries.

Thank you for your interest in and support of OIG's mission and for the opportunity to discuss our work. I am happy to answer any questions you may have.

[12] For more details on OIG's impact, the essential work we have planned, and the resources needed to fulfill these mission-critical activities, see OIG's fiscal year 2015 Congressional budget justification, available at http://oig.hhs.gov/reports-and-publications/budget/index.asp.

Mr. LANKFORD. Thank you.
Ms. Mann?

STATEMENT OF CINDY MANN

Ms. MANN. Good morning, Chairman Lankford, Ranking Member Speier and members of the subcommittee.

Thank you for the opportunity to testify about Medicaid financial management. We understand and appreciate your interest in this very important topic.

Medicaid serves 65 million people with a vast array and diverse array of health care needs. To serve these individuals, states rely on a similarly diverse array of health care providers reflecting their local markets, the needs of the population and the state's preferred approach to delivering and paying for care.

Our program rules attempt to accommodate this diversity while also assuring access to care for eligible individuals and sound management of program resources.

CMS takes very seriously our responsibility to ensure proper financial management and we are continuing to refine and improve our work driven by a strong and abiding resolve to ensure that all of the dollars that are directed to this program are spent wisely and for the purpose to which they are intended.

Accountability for assuring appropriate financial management lies both with CMS and the states. Our ability at CMS to assure proper financial management depends on a large degree on our ability to explain clearly to states what their responsibilities are with respect to financial management and to use our resources to help them to do as good a job as they can in that area.

It is also important for our responsibilities to be executed properly to focus on areas where state and federal interests may diverge.

My colleagues with me today are key partners in that effort. Both the HHS OIG and the GAO provide valuable state and issue specific analyses on which we routinely rely on. I would like to acknowledge their work and their contributions.

I want to use my time this morning to outline just a few of the steps we have recently taken to improve financial management. The committee has looked closely over the period of the last couple of years on the issue of federal upper payment limits.

Consistent with the commitments that we made to this committee in March 2013, we required states to submit annual demonstrations that their federal upper limits were in fact operating consistent with this law.

Until the guidance was issued, states reviewed upper payment limits only when a state made a change. As we saw in the instance of New York, without regular review, an upper payment methodology that was approved decades ago may stay in place and ultimately through the passage of time and events become out of compliance with statutory requirements.

We are now reviewing upper payment limits annually. We have received the first submissions and are reviewing them now.

In May 2014, we issued guidance regarding allowable uses of provider related donations in the context of some public and pri-

vate financing arrangements which also usually involve supplemental payments.

We saw some issues arise in a few states and we thought we needed to be proactive to let states know what we would and would not approve in this area.

Capitated payments to managed care plans account for about 30 percent of all our Medicaid spending. Over the past year, we have significantly deepened our review of managed care rates working hand in hand with our Office of the Actuary and mindful of GAO recommendations in this area.

We have also revamped our payment error rate measurement program, known as PERM, to ensure that states properly implement the eligibility changes ushered in by the Affordable Care Act. PERM error rates in Medicaid have been declining but again, we wanted to be proactive in this area because the eligibility changes affect all states and are significant so we implemented a 50 state strategy so that every state has a PERM eligibility review in 2014, 2015 and 2016. Without this change, only one-third of the states would have been reviewed in each of those years.

We have also invested significant resources in improving the data available to CMS, the states and the public to support program and financial management. These activities are in addition to our regular review of program expenditures.

In my remaining time, let me briefly cover a few points raised by the testimony from Mr. Hagg and the GAO as well.

Ms. Iritani's testimony raises two concerns. One relates to the non-federal share of financing for the Medicaid Program noting that it is within limits and federal law permissions for states to rely on both state general revenues and local revenues.

It is common for states to rely on a mix of state and local revenues when they finance public services. Medicaid is no different and allows for that mix. The GAO's report looks at the increase in reliance on intergovernmental transfers and local government financing during the time of the recession, between 2008 and 2011, where state general revenues were declining. We did see states rely more on local revenues.

States have different reliance on local revenues and the Medicaid Program allows that. There is no finding in the GAO report that anything was in violation of federal law on that.

The second finding in the report is based on a preliminary analysis looking at some upper payment limit supplemental payments to New York hospitals. We have not yet seen the report on which this part of the testimony is based so will be eager to do so.

It certainly raises concerns, not that the upper payment limit was violated—it appears upper payment limit was intact—but questions about payments to a particular hospital. These are safety net hospitals. These were hospitals that are a part of the New York City Health and Hospital Corporation with particularly high needs.

We will look into this payment and certainly commit to ongoing efforts to increase transparency on the payment side of supplemental payments. We believe that is an important step forward and one in which we are already undergoing some work.

Mr. Hagg's testimony focuses on New York. As he noted, New York is a very large and complex program. Our work with New

York, as with other states, is ongoing. The audits Mr. Hagg described are all under active review by CMS.

As the committee knows and as the Chairman referenced in his opening statement, CMS has taken significant action, as has New York, with respect to the payments to both institutional and community-based public providers of services to people with disabilities.

We have adjusted the rates going forward, completed our financial management review with the Office of Inspector General, issued a disallowance for the period covered by the review and the work continues as the Chairman noted.

I will close by reiterating our very strong commitment to program integrity and financial management, including our commitment to continue to improve and enhance our oversight of this very important program.

[Prepared statement of Ms. Mann follows:]

U.S. House Committee on Oversight & Government Reform
Subcommittee on Energy Policy, Health Care & Entitlements
Hearing on CMS's Financial Management of the Medicaid Program
July 29, 2014

Chairman Lankford, Ranking Member Speier, and Members of the Subcommittee, thank you for the invitation to discuss the Centers for Medicare & Medicaid Services' (CMS) oversight of financial management in the Medicaid program. States and the Federal Government share mutual obligations and accountability for the integrity of the Medicaid program and the development, application and improvement of program safeguards necessary to ensure proper and appropriate use of both Federal and state dollars.

This Federal-state partnership is central to the success of the Medicaid program, but it depends on clear lines of responsibility and shared expectations. CMS takes seriously our role in overseeing the financing of states' Medicaid programs, and we continue to look for ways to refine and further improve our processes.

Medicaid Background

Medicaid is the primary source of medical assistance for millions of low-income and disabled Americans, providing health coverage to many of those who would otherwise be unable to obtain health insurance. In FY 2014, an estimated 65 million people on average will receive health care coverage through Medicaid.

Although the Federal Government establishes general guidelines for the program, states design, implement, and administer their own Medicaid programs. The Federal Government matches state expenditures on medical assistance based on the Federal medical assistance percentage (FMAP), which can be no lower than 50 percent.

States that choose to participate in the Medicaid program and receive Federal matching payments are required to cover individuals who meet certain minimum categorical and financial eligibility standards. Under Medicaid, states must cover certain medical services and are provided the flexibility to offer additional benefits to beneficiaries. Unlike most other types of coverage,

Medicaid has a major responsibility for providing long-term care services. Medicare and private health insurance generally furnish only limited coverage of these benefits. State governments have a great deal of programmatic flexibility within which to tailor their Medicaid programs to their unique political, budgetary, and economic environments. As a result, there is variation among the states in eligibility, services and service delivery, as well as reimbursement rates to providers and health plans.

Medicaid is currently undergoing significant change as CMS and states implement reforms to modernize and strengthen the program and its services. While focused on implementation of the Affordable Care Act, CMS has been working closely with states to implement delivery system and payment reforms. CMS has encouraged state efforts with new tools and strategies to improve the quality of care and health outcomes for beneficiaries and to promote efficiency and cost effectiveness in Medicaid. And, as always, CMS works to ensure appropriate financial management mechanisms are in place to ensure dollars are spent appropriately.

CMS has seen many of those efforts pay off in the form of slowed, and in some cases declining, spending. Total Medicaid expenditures increased by only 0.8 percent in FY 2012, which was the second-lowest rate of growth in the program's history. At the same time, while enrollment in Medicaid grew, per enrollee spending is estimated to have decreased by 1.9 percent.[1]

Financial Management in Medicaid

Medicaid's Federal-state matching arrangement reflects the fiscal commitment on the part of the Federal Government towards paying for part of the cost of health and long-term care services for certain categories of low-income Americans. The matching arrangement depends on states' own contributions, which ensure their commitment to managing costs and quality. CMS takes seriously our responsibility to ensure that states correctly report their Medicaid expenditures so that we can ensure Federal Medicaid funds are appropriately spent. Oversight of states' financial management of their Medicaid programs is a critical component of our work.

[1] http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Financing-and-Reimbursement/Downloads/medicaid-actuarial-report-2013.pdf

The Federal Government oversees state Medicaid program implementation in part through review of the state plan. The state plan is an agreement between a state and the Federal Government describing how that state administers its Medicaid program. The plan provides assurances that a state abides by Federal rules and may claim Federal matching funds for its Medicaid program activities. The state plan sets out groups of individuals to be covered, services to be provided, methodologies for provider payment rates, and the administrative requirements that states must meet to participate. States frequently send State Plan Amendments (SPAs) to CMS to review and approve. CMS also reviews managed care contracts and reported expenditures. Some states use program flexibility provided by the Secretary through section 1115 demonstrations to test new or existing approaches to financing and delivering Medicaid and CHIP. When a state is implementing all or part of its Medicaid responsibilities through a section 1115 demonstration, CMS reviews compliance with Federal requirements in approving the demonstration and expenditure authorities and Special Terms and Conditions applicable to the demonstration, and through state reporting requirements that may be implemented through the Special Terms and Conditions. The demonstration authorities, including the Special Terms and Conditions, effectively amend or expand the agreement set forth in the state plan. Together with the state plan, the demonstration authorities describe how the state administers its program for the period of the demonstration. CMS monitoring activities for demonstrations include review of quarterly program reports, evaluation/implementation progress reports, and monitoring the Federal budget limit established for the demonstration against the state's actual reported expenditures to ensure claims are permissible and within the scope of the demonstration's goals and objectives.

To ensure financial stewardship over Federal taxpayer money, CMS verifies that actual state expenditures reconcile with the monetary advance CMS gives to states for their anticipated quarterly budgeted costs. States may submit a revised request for Federal funds if their original request proves insufficient, but they must provide justification for doing so. Thirty days after the end of the budget quarter, states must report actual expenditures and include supporting documentation such as invoices, cost reports, and eligibility records to ensure that the Federal financial participation (FFP) matches with states' actual expenditures. This process applies

whether or not some or all of a state's expenditures are authorized through the state plan or a section 1115 demonstration.

CMS employs a team of accountants and financial management specialists in regional offices to review these submissions, look for anomalies, and request additional documentation or justifications as necessary. These individuals also perform focused financial management reviews of specific Medicaid service and administrative expenditures. Focused financial management reviews generally involve selecting a sample of paid claims for review related to certain types of Medicaid provided services. These reviews are useful in identifying unallowable costs and in highlighting where additional policy clarification or oversight may be needed. These accountants and financial management specialists also perform audit resolution tasks and coordinate with state auditors and the Department of Health and Human Services' Office of the Inspector General (HHS OIG) to ensure state expenditures and corresponding claims for Federal matching funds are allowable.

CMS issues deferrals and disallowances to states that provide inadequate documentation or justification for Medicaid claims. A deferral withholds funds from the states until additional clarification or documentation is received from the states regarding Medicaid expenditures claimed. A disallowance is a determination by CMS that a claim or portion of a claim by a state for Federal funds is unallowable or is not supported by the state's documentation. States have the right to appeal a disallowance, in whole or in part. CMS oversight over state expenditures is a careful balance of ensuring that states receive the guaranteed Federal share, while also ensuring the FFP is only spent on appropriate, documented activities in the Medicaid program. As part of achieving that goal, as of FY 2013, CMS identified from state reported expenditures approximately $9.7 billion in questionable Medicaid costs. In FY 2013 CMS took action on an estimated $2.7 billion (with approximately $375 million recovered and $2.4 billion resolved). Furthermore, an estimated $188 million in questionable reimbursement to states was averted due to CMS funding specialists' preventive work with states to promote proper state Medicaid financing.

Finally, as part of our ongoing financial management oversight, CMS provides regular updates through the budget and expenditure reporting system related to proper claiming of expenditures. And in spring 2014, CMS provided in-depth training to states on the budget and expenditure claiming forms.

Rate-Setting and Program Oversight

Medicaid beneficiaries access services through both fee-for-service (FFS) and managed care arrangements. As described above, the state plan sets out the methodologies for establishing the fee-for-service payment rates for providers. To change the way a state pays Medicaid providers in this context, a state must submit a SPA to CMS to review and approve. Before the SPA's effective date, the state must also issue a public notice of the change. The notification is to inform providers and other stakeholders of changes to Medicaid payment rates.

States develop their payment rates based on many factors, including consideration of local health care markets, the underlying costs of providing the services, and payment rates by Medicare or commercial payers in the local community. Payment rate methodologies often include mechanisms to update the rates based on specified trending factors, including a state-determined inflation adjustment rate. CMS reviews SPA reimbursement methodologies for consistency with the Social Security Act and other Federal statutes and regulations. Section 1902 of the Social Security Act requires that states "assure that payments are consistent with efficiency, economy, and quality of care."

To promote efficiency, economy, and quality of care, CMS sets an outer bound, the Medicaid Upper Payment Limit (UPL), for how much states can pay providers under certain fee-for-service arrangements. The UPL for institutional providers such as hospitals and nursing facilities is not a limit on payments to individual providers, but is calculated in the aggregate for each affected category of Medicaid services and for each provider type (private, non-state-government, and state-government-owned). A SPA proposing to increase payment rates for these services will require the state to demonstrate that the increase in payment rates will not result in total payments for any provider type exceeding the UPL for that category of services.

There is a different standard applied to rates paid in capitated managed care arrangements. Federal law requires Medicaid capitated rate arrangements to be actuarially sound. Under CMS regulations, state contracted actuaries must certify that the rates paid are actuarially sound. As capitated managed care arrangements have become a commonly used approach to Medicaid service delivery and are expected to grow in the coming years as new beneficiaries enroll, CMS has increased our oversight of this rate setting process. For the 2014 contract year, CMS, in collaboration with CMS' Office of the Actuary (OACT), issued a rate-setting consultation guide; held in-depth consultation meetings with states and their consulting actuaries to discuss that guidance; and identified key elements that should be described in the filed rate methodologies. We are working closely with states during this review process in order to ensure rates are actuarially sound and meet all requirements. We are committed to improving our oversight across all capitated contracting arrangements through new initiatives that increase transparency.

Ongoing guidance to states

As part of our ongoing management of the program, CMS regularly provides guidance to states on matters relating to financial management, including two recent letters that detailed our work to improve data analysis and other financial management tools.

The first letter, issued in March 2013[2], announced our intention to work with the National Association of Medicaid Directors (NAMD) to establish an executive workgroup to focus on strengthening financial management and program integrity within the Medicaid program. That workgroup has met regularly and has made substantial progress in expanding state access to Medicare and CMS data for program integrity purposes.

In this same letter, CMS also announced that we would require states to submit UPL demonstrations on an annual basis, allowing CMS and states to have a better understanding of the variables surrounding rate levels, supplemental payments and total providers participating in the programs and the funding supporting each of the payments described in the UPL demonstration. Previously this information was collected or updated only when a state was proposing an amendment to a reimbursement methodology in its Medicaid state plan.

[2] http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-13-003-02.pdf

Specifically, beginning in 2013, CMS required that states submit UPL demonstrations for inpatient hospital services, outpatient hospital services, and nursing facilities. In 2014 and annually thereafter, states will be required to submit annual UPL demonstrations for the services listed above and clinics, physician services (for states that reimburse targeted physician supplemental payments), intermediate care facilities for the developmentally disabled (ICF/DD), psychiatric residential treatment facilities and institutions for mental disease (IMDs). This information must be submitted by the state prior to the start of the state fiscal year. For most states, this means that a state submits, for CMS review, these UPL demonstrations by June 30th of each year. CMS has received the first round of these submissions from states and is currently reviewing them.

More recently, CMS issued guidance related to the allowable and unallowable use of provider-related donations and the use of certain types of public-private arrangements.[3] These arrangements generally involve Medicaid supplemental payments or special add-ons to the base payment rate that are contingent upon or otherwise related to agreements between government and private entities under which the private entities assume obligations to provide donated services or other transfers of value as directed in the arrangements.

Our goal in providing this guidance is to clarify for states what is authorized under the law and ensure that states have the information and support they need from CMS to promote flexibility while ensuring compliance with Federal statute and regulations. The guidance is coupled with ongoing work with states as questions about these and related matters arise in the course of SPA review and financial management oversight.

Further Initiatives to Strengthen Medicaid and Ensure Financial Integrity

As the Federal-state partnership evolves, CMS continually updates and improves our financial management functions incorporating them into our day to day work. Over the last several years, we have undertaken several initiatives that build upon our existing programs and tools.

Improving Data and Data Analytic Capacity

[3] http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-14-004.pdf

Programs with the size and scope of Medicaid and the Children's Health Insurance Program (CHIP) require robust, timely, and accurate data in order to ensure the highest financial and program performance, support policy analysis and ongoing improvement, identify potential fraud or waste, and enable data-driven decision making. Section 4735 of the Balanced Budget Act of 1997 included a statutory requirement for states to submit claims data, enrollee encounter data, and supporting information. Section 6504 of the Affordable Care Act strengthened this provision by requiring states to include data elements the Secretary determines necessary for program integrity, program oversight, and administration.

CMS has worked with states to improve Medicaid and CHIP data and data analytic capacity through the Medicaid and CHIP Business Information Solutions (MACBIS) initiative. This initiative includes changes to the Medicaid Statistical Information System (MSIS), which will be known as Transformed-MSIS or T-MSIS. We will be implementing T-MSIS with states on a rolling basis, beginning this summer.

The enhanced data available from T-MSIS will support improved program and financial management and more robust evaluations of demonstration programs. It will also enhance the ability to identify potential fraud and improve program efficiency.

Enhancing the Payment Error Rate Measurement (PERM) Program

The Affordable Care Act created significant changes to Medicaid and CHIP eligibility applicable to all states regardless of their decision to expand Medicaid. These changes require redesign of many Medicaid and CHIP business operations and systems, and interaction with other state and Federal partners.

In light of the importance of these changes in policy, operations, and systems, CMS and the states have a strong interest in ensuring timely feedback about the accuracy of determinations based on these changes and ways to quickly create improvements or corrections based on those results. The interaction of the Marketplaces, Medicaid, and CHIP, and the cross-program interdependencies and coordination built to create an efficient system of coverage, will need special consideration in the planning of future program measurements and accountability. Accordingly, the current methodologies applied to measurement of eligibility accuracy under

PERM need to be updated to reflect the changes states are making in their eligibility processes and systems and incorporate new regulations concerning the above changes.

For this reason, starting in 2014, CMS has implemented an annual 50-state pilot program strategy with rapid feedback for improvement, in state eligibility systems and eligibility determination processes in place of the Payment Error Rate Measurement (PERM) and the Medicaid Eligibility Quality Control eligibility reviews through 2016. The Medicaid and CHIP Eligibility Review Pilots will use targeted measurements to: (1) provide state-by-state programmatic assessments of the performance of new processes and systems in adjudicating eligibility; (2) identify strengths and weaknesses in operations and systems leading to errors; and (3) test the effectiveness of corrections and improvements in reducing or eliminating those errors.

Oversight of Non-Federal Share Funding

The Medicaid statute provides states with the discretion to finance the non-Federal share of program costs from a variety of sources including state general funds, special assessments, funds derived from health care related taxes or contributions from units of government through intergovernmental transfers (IGTs) and certified public expenditures (CPEs). Each type of non-Federal share funding is subject to Federal guidelines and oversight, and the statute provides that no more than 60 percent of a state's non-Federal share can be from local sources. At least 40 percent must be from state funds. This analysis is made at an aggregate state expenditure level including both medical assistance expenditures as well as state administrative expenditures.

States are specifically permitted in statute to source the non-Federal share through these mechanisms. Moreover, during the economic downturn, some states relied less on state general funds and more on other sources of funds, consistent with Federal law. This allowed funding for Medicaid services to be available even when state tax revenues were constrained. In instances where states are found to rely on Federal funds through funding or payment arrangements that do not adhere to Federal requirements, CMS has proactively addressed those issues through SPA disapprovals or other oversight and regulatory measures.

CMS thoroughly reviews the financing associated with each SPA that states submit to propose changes to service payments. With each request, CMS gathers information on the source of the

non-Federal share, the units of government that IGT funds or use CPEs, as well as supporting documentation related to health care-related taxes and provider-related donations. The information is analyzed and must be determined as an acceptable basis to serve as a source of the non-Federal share before CMS approves a SPA proposal.

Our Work Continues

CMS takes very seriously our responsibility to oversee taxpayer dollars, while ensuring Medicaid beneficiaries receive the services to which they are entitled. Financial management is a critical component of our day to day work on the Medicaid program, and we continue to look for ways to improve and enhance our approach to oversight of this important program. We are working closely with states to ensure they are upholding their end of the bargain and meeting the financial management practices expected of them.

I look forward to working with the Committee as we continue to improve the Medicaid program.

Mr. LANKFORD. Thank you. I will recognize myself for five minutes of questioning.

Ms. Mann, have you all done an estimate of the cost of the paperwork just to fulfill the requirements from Medicaid for hospital providers and such?

What was the typical estimate of the cost for them to be able to fulfill the paperwork requirements?

Ms. MANN. Mr. Chairman, I am not sure there are many paperwork requirements for hospitals to support their claims to states, to support their claims to the managed care plans. We do not require direct paperwork submissions from the hospitals. We do not pay the claims directly. The states would do that.

Mr. LANKFORD. I understand that. Part of the challenge we have here is the transparency side of how things are paid. It has already come up. We pull the documentation so we know how to be able to track that.

Is there some sort of ballpark guess, if you are going to be in the Medicaid Program, obviously the states are running the program day to day, what the cost is for the hospital or the provider to be able to do separate from the cost to actually provide for the patients themselves?

Ms. MANN. The hospitals would be the best judge of that. Obviously their decision to participate in the Medicaid Program is theirs, so they determine that it is cost effective for them to do so.

Overall, the Medicaid Program spends less than five percent or about five percent on administrative costs.

Mr. LANKFORD. Medicaid spends five percent in Washington, D.C. or in the hospitals themselves, it is a five percent cost?

Ms. MANN. Overall, nationwide, in terms of public dollars, state and federal dollars, I would have to look into what a hospital might spend itself on complying with federal Medicaid requirements and how that compares to complying with private insurer requirements.

For example, there are certainly paperwork requirements. states need to substantiate the claims and make sure they are well documented.

Mr. LANKFORD. Right now, you are saying the administrative cost for states and local governments and the Federal Government is five percent for Medicaid?

Ms. MANN. Overall, of our expenditures, that is correct.

Mr. LANKFORD. But you don't know what it is for the hospitals at this point?

Ms. MANN. No, and I am sure it would vary significantly.

Mr. LANKFORD. I am confident that it would. I understand that—day to day, different operations of different hospitals.

You mentioned in your testimony, Ms. Mann, that "We saw issues arise in a few states on the state-provided share for that." What do you mean by that?

Ms. MANN. There was a state plan amendment that we received from one state, the state of Louisiana that raised questions for us about these public/private arrangements. We denied that state plan amendment.

Mr. LANKFORD. Why?

Ms. MANN. Because we determined that the state plan amendment was about permission to do supplemental payments. In all of

our inquiries about supplemental payments, we ask for the non-federal financing for the supplemental payment.

We determined that it was based on provider donations that we felt violated our provider donation rules and that, as such, we could not approve the supplemental payment. We are now moving forward with action around the provider donation itself.

We were concerned that this kind of practice might spread and we wanted to make sure that it didn't and so decided to issue a national guidance on it.

Mr. LANKFORD. For a local government to be able to kick in some of the funding, the non-federal share and a state government to do that in a non-federal share, I understand that. Tell me about the provider tax. Where does that fit into this?

Ms. MANN. This was a provider donation so we have rules that govern when a health care provider can also finance a non-federal share of the program. They might do so through a donation, through a provider tax—Congress has established pretty elaborate rules and we implemented those rules through regulations—to prevent essentially a recycling so that a provider can make a donation, receive payment back from the Federal Government through the state and in fact not have Medicaid service to show for it.

We felt that the provider donation in this circumstance violated the federal rules and we disapproved the supplemental payment and acted to provide national guidance.

Mr. LANKFORD. Ms. Iritani, you mentioned a couple times in your testimony the provider payments, these provider tax issues and the non-federal share. Where do you think the providers are coming up with those dollars? Hospitals don't have a lot of money either at this point.

When hospitals are providing a provider tax to be able to provide this non-federal share, where is that money coming from?

Ms. IRITANI. We haven't looked at where providers are getting the money but in the three examples we have in our report, we looked at financing arrangements in three states, including two that involved provider taxes.

We looked at the effect of the arrangement and estimated if the arrangement had not been put in place, what the federal share would have been. In each case, we found the federal share increased, the payment to the providers increased, and the state's share remained the same or decreased.

Mr. LANKFORD. I would like to recognize the Ranking Member of the full committee, Mr. Cummings, for his questions.

Mr. CUMMINGS. Thank you, Mr. Chairman.

Ms. Mann, when Congress passed the Affordable Care Act, we included a very important provision that allows states to expand their Medicaid programs. States can now provide Medicaid services to their constituents with families below 138 percent of the poverty line.

As a result, millions of families, children, pregnant women and many others are now able to get critical medical services like doctor's visits, prescription drugs and preventive care.

As a part of this program, Congress pays 100 percent of the cost for three years. After that, the amount declines to 90 percent and the states pay 10 percent. Is that correct?

Ms. MANN. That is correct.

Mr. CUMMINGS. This is a great deal for states because it allows them to cover millions of additional people who are their constituents, people who otherwise might be going to emergency rooms for uncompensated care.

It provides a huge boost to state's budgets, creates jobs and health care providers across the Country support it but not all states are doing it. states with democratic governors all support expanding Medicaid but Republican governors disagree among themselves with wildly differing explanations.

For example, Jan Brewer, the Governor of Arizona, stated that expanding Medicaid "would extend cost effective care to Arizona's working poor using the very tax dollars our citizens already pay to the Federal Government."

She added, "It will help prevent our rural safety net hospitals from closing their doors and boost our economy by creating more than 20,000 jobs at a time when Arizona needs them most."

Similarly, Ohio Governor John Kasich stated, and Ms. Speier talked about this a little earlier, "It is going to save lives," which I guess means if they don't have it, there will be people who will probably die. He went on to say, "It is going to help people and you tell me what is more important than that."

Ms. Mann, are you familiar with the fact that these two governors supported expanding Medicaid in their states?

Ms. MANN. Yes, I am.

Mr. CUMMINGS. On the other hand, some Republican governors opposed Medicaid expansion and they claim the exact opposite that it will cost the state too much money and they will lose jobs.

For example, Texas Governor Rick Perry stated, "It is like putting 1,000 more people on the Titanic when you knew what was going to happen." Florida Governor Rick Scott stated, "It will be a big job killer because it will cost too much."

Ms. Mann, all Democratic governors agree that this program is a great deal for their states and constituents but Republican governors disagree with each other with some fully supporting and others claiming it will be the end of the world. Do you know why that is and do you have an opinion on that?

Ms. MANN. I will say I think there is more bipartisan agreement than maybe those numbers might indicate. Many of the Democratic governors that supported and enacted expansion have legislators controlled by the Republicans and we are seeing additional states consider Medicaid expansion for the reasons you have outlined, Mr. Cummings, because it helps the residents of their states, reduces uncompensated care, brings in important federal dollars to the state and obviates the need for state and local governments to be able to pay for services that now can be covered because people have insurance.

It makes good fiscal sense, makes good moral sense and increasingly, we see states and state legislatures rethinking their decision about the Medicaid expansion.

Mr. CUMMINGS. To me this should not be based on politics, should not be based on whether a particular governor is a Republican opposed to the Affordable Care Act for political reasons.

This should be based on the facts and the data. Today, I sent letters to six Republican governors, three who support Medicaid expansion for their constituents and three who oppose it. I ask unanimous consent that those six letters be made a part of the record, Mr. Chairman.

Mr. LANKFORD. Without objection.

Mr. CUMMINGS. Ms. Mann, I didn't ask them for rhetoric or political position. I asked them for the actual data analysis that they relied on in making their decisions. How much did they estimate the expansion would save or cost, how many of their people would be helped or hurt, and how would their state budget be affected, positively or negatively.

My last question to you is whether GAO would be willing to assist us in reviewing their responses. I really want to see what they say. Would you help us analyze this data and these reports so that we can evaluate them thoroughly and better understand their decisions?

Ms. MANN. The question is for GAO?

Mr. CUMMINGS. Yes, GAO. Would you help us do that?

Ms. IRITANI. We are happy to work with your staff on that.

Mr. CUMMINGS. Thank you very much.

I see my time has expired. Thank you, Mr. Chairman.

Mr. LANKFORD. Mr. Walberg?

Mr. WALBERG. Thank you, Mr. Chairman.

Thanks to the witnesses for being here today.

Ms. Iritani, as I understand, GAO found evidence that states were under reporting information on funds received from the providers and local governments. Can you discuss your findings further?

Ms. IRITANI. Certainly. states are required to report provider taxes to CMS on the expenditure reports known as the CMS 64.

We surveyed states to identify provider taxes and we discovered there were six states that had reported provider taxes to us that were not reported on the CMS 64. CMS officials also agreed that the state reported provider tax information is not reliable or complete.

Mr. WALBERG. I assume the reason that is important is for efficiency?

Ms. IRITANI. For oversight. There are requirements around provider taxes in terms of certain federal limits and parameters.

Mr. WALBERG. Ms. Mann, I assume that you are concerned about the fact that states are under reporting the payments. What has CMS done to address this problem?

Ms. MANN. Absolutely, we are concerned. We require the 64 reporting and I underscore the word require. It is a requirement, not an option, with states. I think both in the area of provider taxes and the area of supplemental payments we have increased our efforts to assure proper reporting on the 64s.

I think the reporting has increased significantly. I don't think it is 100 percent there and we are working very hard to make sure it is 100 percent there as it should be.

Mr. WALBERG. Any specifics on how you are doing that to get the 100 percent?

Ms. MANN. We are reaching out to every one of the states. We do approve provider taxes so we have information about provider taxes from different mechanisms so we are cross walking our information in particular our regional offices. We have ten regional offices around the Country and we are specifically reaching out to every state to underscore the importance of proper reporting on the 64.

We have also revised our 64 this year to add some additional items for reporting. We certainly agree with the GAO that transparency and having proper information is key to good oversight.

Mr. WALBERG. Ms. Iritani, I understand another GAO study on payments to government-owned providers was hampered by poor data and state records. Can you describe some of the challenges that the GAO encountered?

Ms. IRITANI. Certainly. We attempted to identify payments to government providers that states were making. In doing so, we tried to combine data that only states have on supplemental payments they make with the claims data at the federal level on payments to providers.

The problems we faced were significant. As an example, states may pay providers using different provider identifiers than what is captured in the federal claims data. states may use multiple state identifiers in paying providers supplemental payments.

We found that one state we contacted didn't have a crosswalk between the national provider identifier.

Mr. WALBERG. What state was that?

Ms. IRITANI. That was California. It didn't have a crosswalk so that we could not match the state-provided data with the federal data very easily.

Mr. WALBERG. As I understand, federal law requires that Medicaid payments are efficient and economical, correct?

Ms. IRITANI. That is correct.

Mr. WALBERG. Given that we don't know how much providers are receiving through supplemental payments, is it impossible for CMS to verify whether payments satisfy the efficient and economical criteria?

Ms. IRITANI. Certainly not for those providers receiving the large supplemental payments that only states capture data for. We estimate that about $43 billion in supplemental payments were likely not captured in the federal data. That is quite a bit of money.

Mr. WALBERG. I see my time is about to expire, so I yield back.

Mr. LANKFORD. Ms. Speier?

Ms. SPEIER. Thank you, Mr. Chairman.

Thank you, again, to our witnesses.

Let me ask you, Ms. Mann, on the issue of provider donations, it is kind of an odd concept to me. I think probably what we are talking about is uncompensated care that is being provided by these hospitals because we, in the Federal Government, have required that anyone who shows up at an emergency room, regardless of their ability to pay, must receive care. Is that a fair assumption?

Ms. MANN. You are right, that may be considered a provider donation in the broader sense, but under our federal law, that is not the kind of donation we would be looking for. I think they are gen-

erally rare. In the case I referenced, it was around a lease agreement for a private hospital to agree to provide some services to the state that ended up being treated as a donation.

Ms. SPEIER. It is unusual to have provider donations is what it sounds like?

Ms. MANN. It is not that common for the reasons you would imagine.

Ms. SPEIER. Mr. Hagg made the point that it is really important for CMS to take the example of New York because he doesn't presume it to be isolated and look across the Country to see to what extent that has happened in other states. Have you done that?

Ms. MANN. Absolutely, and we take our information from our experience overseeing financial management in all the states to think about how to move forward in New York. For example, we issued guidance to all 50 states around annual demonstration of the upper payment limit, exactly the issue we identified as the problem in New York.

Ms. SPEIER. I want to ask a more specific question. Have you looked at other states to see if there have been overpayments so that you might be able to claw that back?

Ms. MANN. Yes. We have required annual submissions and we look at their data to be able to see if there are overpayments.

Ms. SPEIER. Have there been any overpayments?

Ms. MANN. We are still looking at the first submissions provided by states. They were just submitted in 2014. We are looking at that now.

Also, right after New York, we determined some of the issues with the New York upper payment limit, that it was an old state plan amendment that had an automatic escalator. We looked at every state to see what upper payment limit methodologies we had accrued over the decade with automatic escalators.

We determined none had the kind of problem we identified in New York. We are taking a number of different steps to be able to see immediately and then over time, whether these problems arise in other contexts.

Ms. SPEIER. Are you going to claw back the money in New York? Have you taken steps to do that?

Ms. MANN. We have issued a disallowance in New York. We issued the disallowance on last Friday of $1.257 billion for the year covered by the financial management review. We have worked with New York and effective April 2013, their rates to the residential developmental disability centers were lowered by about 75 percent.

We are going to do a further adjustment of that amount based on the financial reviews Going forward, since April 2013, those rates have been righted.

We have also addressed the payments rates for their home and community-based service waiver public providers. We have reached agreement with New York. That is also retroactive to April 2013 and the work continues.

Ms. SPEIER. Good. Mr. Hagg also referenced the rehabilitation services in New York and that you should look at them as well. Have you done that?

Ms. MANN. We are looking at all the audits that OIG has done in New York. They are all under active review. Some have cleared

our review which means we have come to an agreement with the OIG and its findings and will do further work with New York to do recovery.

Ms. SPEIER. Thank you. I am going to move on to Ms. Iritani.

The call in your report really is about transparency.

Ms. IRITANI. That is correct.

Ms. SPEIER. If you were to suggest to CMS what steps they should undertake to ensure transparency moving forward in terms of the data they are getting from states, what would that entail?

Ms. IRITANI. We have made a recommendation in our new report that CMS develop a data collection strategy for improving data on the financing side. We have prior recommendations in reports that CMS require provider specific payment reporting so that supplemental payments that states make that are not captured in federal data are visible to the Federal Government for oversight purposes.

Ms. SPEIER. Ms. Mann, are you going to undertake that kind of transparency?

Ms. MANN. Yes. We definitely think that transparency on the payment side is critically important and we do investigate the non-federal share of funding with respect to any action a state is taking individually.

We are looking at different ways to ensure that the rule in law that no more than 40 percent of the non-federal share can be through non-state sources is abided by. There is no indication from the GAO report they were even close to violating that but we do want to be proactive and think about a statewide reporting structure that may capture that information.

Ms. SPEIER. My time has expired. Thank you.

Mr. LANKFORD. Thank you.

Mr. Woodall?

Mr. WOODALL. Thank you, Mr. Chairman.

Thank you all for being here today. I wanted to follow up a bit on what Mr. Cummings asked.

Ms. Mann, Mr. Cummings and you discussed the state Medicaid expansion. What are we looking at in terms of dollars for 2014? I have seen dollars for 2012, 2011, 2008. What are the expected federal Medicaid outlays for this calendar year?

Ms. MANN. About $308 billion.

Mr. WOODALL. Thinking back to 2012 before the Medicaid expansion, it was $251 billion and is $308 billion this time. That is about a 20 percent increase. Do you attribute the increase in Medicaid spending predominantly to the expansion through the Affordable Care Act or do you attribute it predominantly elsewhere?

Ms. MANN. I don't have the earlier number you referred to so I can't comment on the 20 percent increase. I don't think it was that high.

Mr. WOODALL. How many new people are we trying to add? Can you compare the Medicaid population from last year to the hopeful Medicaid population this year?

Ms. MANN. Sure. We have been doing monthly data reporting on the changes in enrollment in the Medicaid program, not limited to the new eligibles but overall Medicaid enrollment.

Compared to pre-October 1, 2013, the enrollment has increased across all states by 6.7 million people.

Mr. WOODALL. That is an increase of what percent?

Ms. MANN. We cover about 65 million people.

Mr. WOODALL. About a 10 percent increase in the number of folks who are there?

Ms. MANN. That is right, more as you might expect in the expansion states, a greater percentage increase in the expansion states and less so although still some increase in the states that chose not to expand.

Mr. WOODALL. I will be interested to see when GAO works with the Ranking Member on the letters he sent out to governors. I don't know if my governor was one of those. I took a little offense to the suggestion that governors oppose it for political reasons.

I think my governor opposes it for financial reasons. I wanted to ask you all about that. Ms. Iritani, I am looking at your report. It tells me that Medicaid is on, and has been for 11 years, on the list of high risk programs. What has to happen to end up on a list of high risk programs? That does not sound like an accolade, it sounds like a warning sign.

Ms. IRITANI. GAO's high risk list is put together based on work that we do and concerns that GAO has about risks related to fraud, waste, abuse, mismanagement or programs in need of broad transformation.

In Medicaid's case, we put Medicaid on our high risk list because of concerns about oversight as well as the significant growth in the program, as well as the diversity and challenges of oversight.

Mr. WOODALL. That is certainly where I would characterize our governor as being, that if you have a program in need of dramatic transformation, this might not be the right time to try to ramp up enrollment.

I am looking at your report, Mr. Hagg. I think I have misread it. It said that the IG's efforts to identify improper state claims exceed $450 billion, a half trillion dollars is what the IG's office has identified in improper state claims.

Mr. HAGG. No, that is the total Medicaid spending for I think 2013, the $450 billion.

Mr. WOODALL. Help me to understand. It says, "Thank you for the opportunity to testify on ongoing efforts to identify improper state claim to federal Medicaid dollars, federal and state outlays exceed"—I see exactly what you are saying.

As the IG is trying to develop its strategy, are you trying to identify dollar values, or are you trying to identify the number of people affected? How do you direct your limited efforts in such a large program?

Mr. HAGG. It is both. Certainly we try to focus where the dollars go, so we do spend a lot of time auditing states like New York and some of the other states, Texas and California. We focus on quality of care type issues and try to make sure that the Medicaid beneficiaries are receiving proper services.

We try to look for areas we believe to be high risk, the areas that sort of stand out compared to others and try to direct our limited resources to those high risk areas.

Mr. WOODALL. I see my time has expired.

Mr. LANKFORD. Mr. Davis?

Mr. DAVIS. Thank you very much, Mr. Chairman.

Although I am not a member of this subcommittee, I thank you for the opportunity to participate.

Mr. LANKFORD. Mr. Davis, would you yield for a moment?

Mr. DAVIS. Yes.

Mr. LANKFORD. I would ask unanimous consent to include Mr. Davis and Mrs. Maloney both on this panel for this discussion today. Without objection, so ordered.

Now you are on our panel. How about that?

Mr. DAVIS. I am delighted.

I have been around health care, I guess, for about 40 years. I have always held that when we passed Medicare and Medicaid, those were two of the most effective and best decisions that this Country has ever made relative to trying to make sure that low income people had access to a level of health care.

Ms. Mann, let me ask, have you observed any changes in life expectancy and quality of life since we passed those measures?

Ms. MANN. I appreciate your comments. Yes, we have seen extraordinary changes in the day to day lives of people. We have healthy Americans who no longer have the insecurity of knowing that if something happens to their family member, they could go bankrupt, they could lose their home, or they could lose their resources.

We have enrollment campaigns all the time and have had it for years since the Medicaid and CHIP programs were passed. We have the testimony from parents about what it means for them to know their child has the security of coverage.

We also know people have significant illnesses. They get cancer treatments that they wouldn't be able to get with the absence of coverage. They get the benefits of having home and community-based services that allow them to live, notwithstanding significant disabilities or chronic illnesses, in their homes and still be active members of the community.

It goes well beyond the actual health outcomes but really to their ability to live their lives and contribute to their communities.

Mr. DAVIS. Let me say I greatly appreciate the work of each of the agencies represented, but I have always found CMS to be a pretty tough outfit in terms of what it is that it does and the impact it has on health care delivery with hospitals and other providers.

I happen to represent more hospitals than any other congressional district in America and also a large number of medical schools and large poor populations, individuals who are at or below the poverty line.

I know Illinois has been mentioned in these discussions a little bit but looking at New York, is there anything unique that you find about the New York population, especially in say New York City, that is being treated and makes use of Medicaid?

Ms. MANN. We certainly see many positive steps in New York. New York was one of the early states to adopt managed care to begin to move towards a more integrated delivery system to provide services to individuals. It was one of the leaders in that and then proceeded to expand its managed care in a slow and careful way. I think by and large it has done a good job.

It has embarked on a recent initiative to improve delivery of services and to integrate those services better. It is a very hospital-based system, particularly in New York City. I think the effort now is to assure there are more community-based partners to promote better primary care, to reduce hospital admissions and through those improvements, to lower costs.

New York is a microcosm of the Nation but as we often say, is a little bit more so—many poor people, many hospitals, many providers and juggling a lot of issues with a very large program.

Mr. DAVIS. The characteristics are very similar to much of the population that I represent, so I can appreciate the efforts they have made. I also recognize that you have to pay for what you get but I also believe we have to make sure we get as much out of our resources as we possibly can.

Mr. Chairman, I thank you again. I yield back.

Mr. LANKFORD. Ms. Lujan Grisham?

Ms. GRISHAM. Thank you, Mr. Chairman.

I want to try to refocus on the focus of the hearing which is examining whether or not we are curbing our wasteful spending and looking at whether there are schemes.

In listening to some of the dialogue today, I don't know that I would call them schemes, but in fact, CMS scrutinizes I think to a high degree a variety of mechanisms that states use when their budgets are precarious given the growth in any population.

Take an elderly, aging and disability population receiving institutional care, for example, and the nursing home bed tax which some states successfully did by showing an expansion in those services. states like New Mexico had some trouble including in the Medicaid rate a reimbursement for a tax for the services provided by the nursing homes so that comes back to the state and back into your Medicaid budget and identifying whether or not that gives you an expanded service.

Is that one of those provider donation kind of schemes that we look at across the Country, Ms. Mann?

Ms. MANN. Yes, that can be. Our provider tax rules say the tax has to be broad based so it is not just targeted to Medicaid providers. The refinancing and circular payments that you describe can't happen.

Ms. GRISHAM. Had to be for everybody in the facility, as an example, not just those on Medicaid?

Ms. MANN. That is right and for similar facilities that aren't Medicaid providers.

Ms. GRISHAM. Every facility licensed to provide that care has a tax.

Ms. MANN. I might note we recently issued on Friday further guidance on provider taxes that again looked at a particular practice that we saw might be going on and provided clarification. That was with regard to managed care organizations—okay for a State to construct a broad based tax on managed care organizations, but not just Medicaid managed care organizations because it can lead to exactly the issue you raised.

Ms. GRISHAM. I was trying to get out some testimony about how these work and why they work or not and what your scrutiny or review looks at specifically.

Ms. Iritani, the GAO released a report today on methods like this perhaps that States use to finance their share of Medicaid, correct?

Ms. IRITANI. That is correct.

Ms. GRISHAM. Your report concludes that States have increasingly relied on funds from health care providers and local governments, correct?

Ms. IRITANI. That is correct.

Ms. GRISHAM. Did you conclude in any of these reports that these funds, along with the federal match, the government's match, were being wasted, used fraudulently or abused in any way?

Ms. IRITANI. We did not.

Ms. GRISHAM. I want Medicaid to be leveraged appropriately, ethically, legally, managed effectively, want the growth in the population to be considered and effectively addressed but I am concerned that there are data gaps and transparency issues.

I am committed with this subcommittee and the entire committee and my colleagues to work on those so that we don't jump to conclusions. Unfortunately, that happened in my home state of New Mexico.

The New Mexico Human Services Department prematurely stopped Medicaid payments to 15 non-profit behavioral health providers, that equals 100 percent of them, based on allegations of waste and fraud that have thus far turned out to be false, untrue.

This caused severe disruptions in behavioral health care services for more than 30,000 adults and children, interrupting access to medication, psychiatrists and counselors. As we look at balances about what we are doing, I just want to make sure that we are clear that the report did not find any of these.

Ms. Mann, I am looking forward to having you and hosting you in Albuquerque in August so that we look at increasing access to these very important treatments and making sure these vulnerable populations that Medicaid is intended to serve, as my colleague, Mr. Davis, so artfully reasserted.

The point is I think we should not use unverified allegations of waste as a pretext to make significant changes to important programs like Medicaid which put at risk the very people these programs were designed to serve.

With that, I yield back, Mr. Chairman.

Mr. LANKFORD. Mrs. Maloney?

Mrs. MALONEY. Thank you, Mr. Chairman.

I thank the distinguished panelists for being here today, for testifying and for all of your hard work.

I wish this hearing had chosen to look expansively at the Medicaid Program overall and not just at one specific state, New York, but I recognize that our panelists here today work hard to manage the Medicaid system and program across the Country.

The testimony from GAO correctly points out that the size, growth and diversity of the Medicaid Program presents a challenge to administration and oversight of the program. The challenge in New York is significant.

We invest more in our Medicaid population than any other state, offering coverage to more than 5 million New Yorkers. For these individuals, Medicaid is a lifeline and Governor Cuomo has taken seriously the long term sustainability of the program.

One of his first initiatives as governor was to launch a Medicaid redesign team which saved $2 billion in its first year alone.

First of all, I would like to ask Mr. Hagg, you have released a series of reports on improper payments in the New York Medicaid system. Is that correct?

Mr. HAGG. That is correct.

Mrs. MALONEY. Have you done a report similar to this in other states?

Mr. HAGG. We have not. At the committee's request, we focused, in the testimony, on eight different Medicaid audit issues in New York that we have issued over the past year.

Mrs. MALONEY. Why did you just focus on New York?

Mr. HAGG. It was at the committee's request.

Mrs. MALONEY. Are there other states that you think have similar challenges as New York?

Mr. HAGG. Yes. New York receives a large amount of federal Medicaid reimbursement. Based on that and other factors, we do spend a lot of time in New York conducting audits on an annual basis.

We also spend time auditing many other states throughout the Country, including larger states like California and Texas.

Mrs. MALONEY. This specific type of report is only for New York, so some of the other states that have similar populations—New York is an immigration center, New York has a high number of disadvantaged, struggling new immigrants, so we help these people.

There are other states that have the same types of challenges. Why aren't you doing reports on them?

Mr. HAGG. We do issue reports on many states throughout the Country. On an annual basis, we probably issue 75 or so Medicaid audit reports.

Mrs. MALONEY. Similar to this report?

Mr. HAGG. If you refer to the letter we sent to the committee that focused on the eight individual New York reports we have issued over the past year, that letter focuses on New York because that is what we were asked to talk about in that letter.

Mrs. MALONEY. I would like you to come back on other states. Let us look and see if this challenge is the same in other states with populations like this. Were your findings in this series of audits similar to the findings in other states?

Mr. HAGG. Yes.

Mrs. MALONEY. So it was similar to other states. Was the rate of error unusually relative to other programs?

Mr. HAGG. In New York, the reports we focused on fell into two categories. One, it had to do with how the state was paying individual providers like home health providers. The second category was on the payment methodologies used by the state to pay state-operated facilities.

In those two categories, we have done similar work in other states, so in New York we have performed home health audits and have performed home health audits in others as well.

Mrs. MALONEY. My question is, are the challenges similar in other states as in New York?

Mr. HAGG. To some degree, yes. When you talk about home health providers, when the states are trying to make sure that the

payments they are making are following all federal and state rules, there are challenges in other states as there are in New York.

Mrs. MALONEY. Where improper payments are identified, we need to make changes that help ensure that only qualified providers and beneficiaries access Medicaid resources. I am pleased that the supplemental program integrity review issued by CMS found that the New York Office of Medicaid Inspector General did not substantiate reports of systemic failures that would compromise the long term viability of program integrity activities.

That office and its counterparts nationwide are critical to identifying improper payments where they exist and recovering these funds.

We often talk about improper payments. I would like to understand from you what is included in this term. Are improper payments necessarily fraudulent, Mr. Hagg?

Mr. HAGG. No.

Mrs. MALONEY. What are some of the reasons a payment may be classified as improper or noncompliant?

Mr. HAGG. Specific to the reports we issued in New York, it had to do with payments made to providers that did not follow specific, applicable federal and state rules. That was one category.

The second category focused on the payment rates for developmental centers run by the state and residential facilities run by the state. In those cases, we saw that the payments rates were extremely high, much higher than the cost of providing services, much higher than the payments that were made to the private facilities.

We consider those inappropriate payments because they are so much higher that it is so much harder to justify it as being economical.

Mrs. MALONEY. My time has expired. I ask permission of the Chair to submit in writing additional questions to the panelists.

Mr. LANKFORD. Without objection, so ordered.

Mrs. MALONEY. Thank you, Ranking Lady, also for helping us with this hearing.

Thank you so much.

Mr. LANKFORD. Ms. Duckworth.

Ms. DUCKWORTH. Thank you, Mr. Chairman.

The Medicaid Program is a lifeline for the most vulnerable, low income and disabled population in Illinois. For the most high risk portion of society, this program serves a critical purpose, improving health outcomes, improving mental health and decreasing the catastrophic medical expenses. In short, it is a good investment although it would cost taxpayers more money if these folks end up at the emergency rooms.

Since my state of Illinois is one of the examples used in the GAO's report, I wanted to put the discussion into perspective. Illinois receives one of the lowest Medicaid federal matching rates in the country, barely above the minimum required by law, in fact, only 50.76 percent.

It serves 4.3 percent of the Nation's Medicaid population but receives only 3.2 percent of total Medicaid funding. In terms of federal money that reaches our state in general, Illinois ranks 49th in

federal return of all tax dollars. We only receive 56 cents back to Illinois for each dollar our taxpayers send to Washington.

I would like to thank the witnesses for joining us today on this very important topic. Ms. Iritani, are the intergovernmental transfers and provider taxes used by nearly all 50 states to finance their Medicaid programs?

Ms. IRITANI. Could you repeat the question?

Ms. DUCKWORTH. Yes. Are intergovernmental transfers and provider taxes used by nearly all 50 states in the Medicaid Program?

Ms. IRITANI. Yes, that is correct.

Ms. DUCKWORTH. It is not just Illinois that does it?

Ms. IRITANI. That is correct.

Ms. DUCKWORTH. Can you explain why GAO is concerned about states' increasing reliance on these sources of funding to finance the non-federal share of Medicaid?

Ms. IRITANI. Yes. We are concerned about the transparency around how states are financing the non-federal share. There are multiple limits and parameters around, for example, user provided taxes and as Cindy pointed out, the percentage of payments that need to come from state funds. Currently, there is no data at the federal level for monitoring that.

We are also concerned because there is great flexibility under the federal rules for concentrating both on the payment side and on the financing side, the use of things like intergovernmental transfers.

States can require particular facilities to fund all of the non-federal share. It gives states incentives to over pay providers that are financing the non-federal share of the payment. That is part of why we think there is more transparency needed on both the payment side as well as the financing side.

Ms. DUCKWORTH. In addition to greater transparency, I think we all support greater transparency, you are not actually saying to end the intergovernmental transfers but you are just saying you would like to see more transparency?

Ms. IRITANI. Exactly.

Ms. DUCKWORTH. Does the GAO believe it is necessary to adopt proposals made by some of my Republican colleagues to block grants to the Medicaid Program in order to address these issues?

Ms. IRITANI. Our recommendations have been aimed at the Administration and Congress around improving reporting, guidance and auditing of certain high risk payments.

Ms. DUCKWORTH. The GAO recommends a narrow, targeted approached focused on improving the reporting and auditing of the payments but not actually stopping the system or block grants, correct?

Ms. IRITANI. Correct.

Ms. DUCKWORTH. If I correctly understand your answers, these are legitimate, allowable funding streams approved by CMS which provide critical support to state Medicaid programs. Can you explain a bit more what limits exist to their use of IGTs and provider taxes at this point?

Ms. IRITANI. As Cindy mentioned, provider taxes are subject to certain requirements that they be broad based and uniform, and not provide a direct or indirect guarantee that the provider will receive the funds.

There are very few requirements actually on the use of intergovernmental transfers and certified public expenditures.

Ms. DUCKWORTH. Thank you.

At a time when federal budgets are tight, it is really appropriate to consider all potential savings to the government, but I would argue that perhaps the best place to start is not legitimate local funding sources for critical health care programs, especially not at a time when states are under significant budgetary pressure to provide services to their most vulnerable populations.

I really worry that limiting these funding sources will inevitably mean less care for the neediest patients, longer waits for medical care, closed hospitals and layoffs of medical workers.

In a state with a large rural population, that is a significant threat to access to health care for some of the poorest residents of my state. In the long run, this will put more pressure on both federal and local government and not less.

Thank you.

I yield back, Mr. Chairman.

Mr. LANKFORD. Thank you.

As this committee is well aware, this is the second round of questioning, so there will be no clock during this questioning and members may interject at any time to be able to have colloquy during any part of the questioning. The same pertains to the witnesses as well. If you want to interject, you do not have to wait to be recognized. This is the more free flowing part of our conversation.

I do want to ask the question because the Medicaid Program has been on the high risk list for so long. How do they get off? What would be needed for you to see and say okay, they are no longer on there because this has been taken care of?

Ms. IRITANI. We have multiple reports with multiple recommendations that have not been implemented by the Administration as of yet. For a first step, we believe the Administration should implement our recommendations in the case of financing and payments in terms of more auditing, more reporting and more guidance.

Ms. SPEIER. Mr. Chairman, will you yield?

Mr. LANKFORD. Absolutely.

Ms. SPEIER. I actually applaud the high risk list that GAO puts out. We should use it as guidance as we review various agencies.

One of the other big agencies that has been on the high risk list, as I understand, for a very long time is the Department of Defense, is that not true?

Ms. IRITANI. I cannot speak to that.

Ms. SPEIER. I can speak to it. Thank you.

In truth, we have high risk in many areas within the Federal Government.

Ms. IRITANI. There are many areas, yes.

Mr. LANKFORD. No question and no dispute on that at all. The issue is, it sat out there for a while. We know the issues on DOD, they can't fulfill an audit and that is part of the responsibility that this committee and others will have to be able to make sure they can audit and be able to implement that.

I am trying to determine for CMS specifically, what can be done for Medicaid to begin to move them off that high risk list, in terms

of a list of recommendations that need to be implemented. Ms. Mann, are you familiar with those recommendations?

Ms. MANN. I am familiar with the recommendations. We have agreed with many of them and have implemented many of them and many are being implemented. GAO has been making recommendations about oversight of managed care rates. It is an area in which we have deeply engaged ourselves and our Office of Actuaries.

I think we have made lots of progress on those recommendations. In some part, we are a high risk program because we are a large program. It is right that there be good attention by the GAO, OIG and of course, by CMS and the states on the expenditures in the program.

I want to be clear that we have moved forward with many of the recommendations pretty aggressively and continue to do so.

Mr. LANKFORD. Ms. Iritani, you have a report we just received recently from July of this year. In it on one of the pages you talk about two hospitals in New York that received $416 million in upper payment limit supplementals compared to $70 million in regular payments. Your average on this was $8,800 per day per patient.

Ms. IRITANI. That is correct.

Mr. LANKFORD. How did you find that?

Ms. IRITANI. We worked very hard to obtain from the state the data that only the state maintains on the supplemental payments that they make and to match that with provider specific analysis of the claims data at the federal level to come up with a total amount that individual providers were paid.

We took from the federal data the number of inpatient hospital Medicaid days that each hospital provided and came up with an average per day payment.

Mr. LANKFORD. What is your best guess on how long this kind of thing has gone on?

Ms. IRITANI. In terms of this particular arrangement?

Mr. LANKFORD. Correct.

Ms. IRITANI. I believe the original state plan amendment was approved in the early 2000s.

Mr. LANKFORD. We are talking 12 years or so probably this has happened?

Ms. IRITANI. Because there isn't payment data at the federal level, we did not look at the payments the state was making in prior years. We looked at the most recent.

Mr. LANKFORD. The obvious question for CMS is, how can you miss it? When you have someone who has $70 million in regular payments, $416 million in supplemental payments, is there a system in place that makes that stand out, set off an alarm, something that triggers this is an outlier?

Ms. MANN. We are certainly in agreement around the transparency recommendations and have significantly increased transparency around upper payment limits by facility and audits by facility. We would agree that more transparency is needed.

When you look at base payments compared to DSH supplemental payments, states have multiple methodologies by which they decide to pay different providers. Some receive DSH payments. These in-

dividual hospitals did not receive any disproportionate share hospital payments. Other hospitals might have received those payments but not these supplemental payments.

We need to look at the totality. It was within, we believe—we haven't seen the underlying work that the GAO has done but we believe it was within the underlying limits of the cost based upper payment limit for this class of facilities. That being said, we want to make sure for each of the facilities identified that the payment is fair and efficient.

There are lots of different ways in which hospitals get paid, some through supplemental payments, some through DSH payments and some through base payments.

There is also transparency on the public side. Before we approve the state plan amendment of the supplemental payments, there is a notice that goes out to the community so that other providers as well as the public know what is being proposed by New York. That transparency I think helps within the marketplace.

Mr. LANKFORD. I would completely agree with that. Do you know what the two hospitals are?

Ms. MANN. We believe they are two hospitals within the health and hospital systems that provide rehabilitative services.

Mr. LANKFORD. Do you feel at this point from an initial look that this is appropriate? Other hospitals are paid in other ways. You think this one does a lot to fall within the efficient system?

Ms. MANN. I am sorry. What I am saying is that generally on the issue of base payments and supplemental payments, there are a lot of different factors that go into any hospital payments. We have to look more specifically at these payments and will be glad to do so.

Mr. LANKFORD. The question comes back to transparency then, how do we find this? What can be built into the system because you said lots of people are paid lots of different ways. It is not necessarily going to stand out and no alarm bells go off. We come back to it and say these two hospitals together just for this small group of patients seem to be such an outlier.

You may come back to it and you may report back to this committee and say, no, everything is fine. These are very high risks or high need patients but the initial blush of it looks like an outlier. How did that not pop up?

Ms. MANN. There are a lot of alarm bells that are built into the system right now. We will look into this one and determine whether both payments to these facilities are appropriate but also whether we should take broader steps including the transparency recommendations the General Accounting Office has recommended.

Ms. SPEIER. Mr. Hagg, you actually highlighted rehabilitation services as an area that CMS really needs to look at. I think I asked the question, Ms. Mann, if you were looking at rehabilitation services and you said yes.

Mr. Hagg, what can be done to have a trigger occur to CMS in a way that it hasn't historically?

Mr. HAGG. I think for rehabilitation services, that was through a home and community based waiver. In those situations, it requires more thorough review of the waiver, increased monitoring, and maybe more often looking at the payment methodologies used in those waivers to help develop the payment rates.

Ms. SPEIER. Let us talk about the waivers. Define what the waiver is and how many states have these waivers?

Mr. HAGG. I don't know exactly the number of waivers. Most states use waivers in one way or another. It is a way of saying you are waiving certain Medicaid rules to help with a different part of the program. You are going to provide different types of services that normally aren't provided through Medicaid and CMS waives those provisions so that care can be provided.

Ms. SPEIER. I know California has had waivers. It is a means by which they say we don't have to play by these rules but we will provide all these services with this much money. It is a way of maybe expanding services or doing things differently to maximize benefits and reduce the actual paper.

Mr. HAGG. Very good services can be provided through waivers. The question in our mind here with the work we did, we just say that the payment rates, the payment methodology resulted in payment rates for the public for the state operated residential centers that were like 57 percent above cost that were twice what would be paid to similar private facilities. That is where our concern lies not so much with the service that is being provided but with how much is being paid for the service.

Ms. SPEIER. I am having a little difficulty now trying to understand. If it is more than the private by 50 percent, is that what you just said?

Mr. HAGG. Yes.

Ms. SPEIER. But it is still within the waiver that they were granted, so it sounds like they were playing by a set of rules that everyone agreed to but then when you look at private providers they were actually spending a lot more.

It seems we create a blank check situation conceivably with the waiver that creates that kind of divergence between a private pay and a waiver payment?

Mr. HAGG. The terms and conditions of the waiver were followed in this case. We didn't question cost here. Our report was to CMS and we recommended that CMS and the state work together to get the payment rate for those state facilities more in line with what we believe to be economy and efficiency.

One distinction here is I believe payments made under waiver don't factor into upper payment limits for those facilities. Upper payment limits apply more towards the fee for service payments that are made to hospitals, nursing homes and intermediate care facilities.

Ms. MANN. If I might try to clarify, the particular waivers that we are talking about here are under 1915(c) to provide home and community based services. Many states have them, many states have multiple ones to be able to provide those kinds of services as alternatives to institutional care for people needing long term services.

Our waivers actually do require that the public providers either pay what they pay in private facilities or private providers or what costs are. New York needed to come into compliance with that term of the waiver. They have done so. We have worked with them over the last year to do that. It is retroactive to April 2013. That agreement has been reached so I think that issue has been resolved.

One of the areas we are continuing to do more oversight is in our home and community based waivers. It is different than these other payments.

Ms. SPEIER. In this case the waiver required them to do something they hadn't done?

Ms. MANN. That is correct.

Ms. SPEIER. Even within the waiver, they were not complying?

Ms. MANN. They were not in compliance and were brought into compliance.

Ms. SPEIER. Thank you.

Mr. LANKFORD. Ms. Norton?

Ms. NORTON. I think it is important to clarify that, in other words, the waiver includes and assumes an amount in which you will have to be in compliance. It is not an open ended notion. That wouldn't make any sense or else everyone would want a waiver.

I think this is an important hearing and I thank the Chairman for it. I am sorry I was not able to attend earlier.

As I understand, the states that have foregone Medicaid expansion also have the highest number of uninsured and have always had the highest number of uninsured. I have two questions about those states.

That is a lot of money. Do the billions of dollars that are not being used by those states go to support the states that are using Medicaid expansion?

Ms. MANN. Certainly it is federal taxpayer dollars being used to support the federal share of the Medicaid expansion. Federal taxes are raised throughout the Country. To some extent, yes, there is cross-subsidization that residents of one state may not be getting the benefit of if their state hasn't chosen to expand.

Ms. NORTON. How is the health care of these residents who do not qualify for Medicaid but cannot in their state qualify for expansion, where do they go for health care?

Ms. MANN. Often, they don't get health care. They often don't have a usual place of medical care to get primary care.

Ms. NORTON. But they get sick like everyone else.

Ms. MANN. They get sick like everyone else but the point is they don't get the same health care as someone who is insured. When they get sick like everyone else, they often will turn to the hospital emergency room or if it is a more acute situation, even be admitted to the hospital.

One of the findings for the states that have expanded, we have seen reports coming out of Arkansas and Maryland, for example, of the reduction in emergency utilization and hospital admissions and uncompensated care since those states moved forward with their Medicaid expansions.

Ms. NORTON. That was my next question. Perhaps we are too early in the process to get that assessment from all the states but one of the most important reasons for passing the Affordable Health Care Act was to reduce the use of the emergency room, like going to a major hotel to get your health care. When will we have some sense of the reduction in uncompensated care?

Ms. MANN. We have actually been seeing reports from hospital systems and states around the Country. We would be happy to provide the reports we have seen so far. Obviously, as you note, it is

still a bit early and yet even in this early time, we are already seeing in communities across the Country some significant decline in uncompensated care.

Ms. NORTON. Mr. Chairman, I would like to know what decline, if any, there has been in the District of Columbia. There may be other members who would like to know that kind of information for their own states as well.

Mr. LANKFORD. Absolutely. Is that complete for the District of Columbia at this point or at least some preliminary data?

Ms. MANN. We are not doing the data analysis ourselves. We are more relying on analyses that either the local jurisdiction or their hospital systems have done or universities. We will look at what is available for the District and let the committee know.

Ms. NORTON. I am very unclear on uncompensated care. I thought that once the Affordable Health Care Act passed, there wasn't going to be anymore uncompensated care. You are in a state that has not expanded Medicaid and your hospitals, in particular, are continuing to get people in the emergency room. Is there a process by which you apply to the Federal Government to get uncompensated care the same way you did before the Affordable Health Care Act was passed?

Ms. MANN. There is no federal financing for uncompensated care per se. It is absorbed first by the hospital and then by other payers. It could be state and local payers that are cross-subsidizing. It could be businesses and private payers who are cross-subsidizing so that the hospital can continue to provide a certain degree of uncompensated care.

When more people are covered and there is lower uncompensated care, it is a benefit to all payers of our health care system.

Ms. NORTON. Your testimony is that there is no uncompensated care available for hospitals in states who are accepting people in their hospitals or emergency rooms, there is no channel for uncompensated care from the Federal Government but the law continues that they must provide care for anyone who presents at the hospital?

Ms. MANN. There is no general uncompensated care fund administered by the Federal Government. The Medicaid Program has what is called the Disproportionate Share Hospital Payment Program that provides a capped amount of dollars to states and a key purpose of those dollars is to reimburse hospitals for some of their uncompensated care.

Medicaid has a mechanism to help states and hospitals that is a capped allotment that varies by states and in the Affordable Care Act, anticipating that uncompensated care would be on the decline, Congress reduced the overall level of disproportionate share payments, particularly in the out years.

There is some funding that is available but much of it is absorbed overall by our health care system making our health care system as a whole more costly. It is one of the reasons why providing coverage to everybody can help reduce costs for the Nation as a whole.

Ms. NORTON. Could I just ask for the provision of some more information to you, Mr. Chairman?

Mr. LANKFORD. Sure.

Ms. NORTON. To the extent that you have any information on the effect of the viability of hospitals, particularly in those states which have not expanded Medicaid, I would be very interested in knowing about those hospitals and whether they are experiencing difficulty, whether any have closed and what the viability is and to the extent you have that information, that would be informative.

Mr. LANKFORD. If that information is available, that would be very much appreciated.

Let me add one other piece as well. When is the last time the list of the disproportionate share hospitals changed? How often is that list updated?

Ms. MANN. The states decide which disproportionate hospitals, so there is a federal definition of what a DSH hospital could be. The states then decide which hospitals in their states they will provide payments to and how much those payments will be provided.

We do annual audits, hospital specific audits, of disproportionate share. There is always an evolving list and we have those audits on our website.

Mr. LANKFORD. Medicare/Medicaid as well? I know that is the other side of the building for you, but do you know if the Medicare list has changed or how that is updated?

Ms. MANN. I would want to get back to you precisely on that.

Mr. LANKFORD. We will follow up.

Ms. MANN. Thank you.

Mr. DAVIS. Mr. Chairman, let me just make one point if I could.

I am so delighted that we emphasized earlier that every time there is an improper payment, it does not mean that there is an allegation of fraud nor any kind of scheme. Many of these hospitals, especially disproportionate share hospitals, sometimes will make mistakes or there are errors and payments might be received.

Ms. Mann, I wanted to just ask you are there any provisions relative to recovery and what that actually means? I ask that question because I have come into contact with, and continue to do so, many disproportionate share hospitals which I have that are always seemingly on the ropes. They are always wondering if they are going to be put out of business, if they going to make it, or are they going to be around next year. That level of uncertainty kind of keeps them up in the air.

Are there provisions in terms of looking at these situations a certain way to try and figure out how we can make sure that we salvage them as opposed to causing them to close or go out of business?

Ms. MANN. You are absolutely right. They tend to be very critical providers of services in low income communities. We certainly want, through the Medicaid Program generally and the DSH Program, to afford them some stability.

Obviously the expansion provides the greatest opportunity for some of those hospitals to increase their revenues because they are serving those people who are now uninsured and for whom Medicaid payment could be issued.

We try to provide some predictability on DSH payments. Again, it is a federal/state responsibility in terms of states deciding what those payments would be. The audits provide, I think, some sta-

bility. I think when there is transparency and clarity on payments, then everyone can feel comfortable that my dollars are spent and received correctly and I can continue to receive them subject to the state's decisions.

Let me mention one thing about whether the overpayments—your first comment—are not always because of fraud but often because of just mistakes that are made. In addition, the OIG audits, for example, will look at, as Mr. Hagg testified, whether federal or state requirements are being met beyond federal requirements.

New York, for example, has many requirements that they impose on their providers that are well above what the Federal Government provides. Some of those are excellent requirements for training and certifications. They are not required by federal law but the Office of Inspector General's protocol is to look at violations of those protocols as well as others.

It is a little bit of a double edged sword for states because to the extent they are doing more regulating of providers, they run the risk of sometimes falling short of not always in every situation meeting those requirements. It is an area that we are looking at to see whether that is a way in which we ought to be proceeding in terms of our calculation of overpayments.

Mr. DAVIS. Thank you very much.

Thank you, Mr. Chairman.

Mr. LANKFORD. Ms. Duckworth?

Ms. DUCKWORTH. Thank you, Mr. Chairman.

I would like to hear a bit more about what we are doing to improve oversight of the Medicaid Program, particularly with respect to state financing of the non-federal share, going back to that discussion.

Ms. Mann, can you provide an overview of CMS' upper payment limits demonstration initiative and how it differs from past practice?

Ms. MANN. Sure, I would be glad to.

On the issue of non-federal share, as Ms. Iritani testified, it is allowable for states to use local resources to meet their non-federal share requirement. Many states rely on local revenues. In the state of Colorado, for example, more than half of its state and local revenues are locally generated. Vermont is the opposite, much more State, not local.

States raise their money in different ways and the Medicaid Program allows a recognition of that diversity in how States will raise their money. We ask about non-federal share to make sure it is a proper financing of any action that is before us.

With respect to the upper payment limit itself, which is a cost-based limit as to the amount of total dollars that can be spent to certain classes of providers, we have embarked on a new initiative requiring every State to submit annually demonstrations that their upper payment limit—they used to have to certify, now they have to demonstrate with publicly available data by facility what the costs are so that we are assuring that not only are they computing the upper payment limit correctly but that we compute the upper payment for each State for each class of facility.

That data is publicly available. We are pouring through it now and we will determine whether there are any particular payments

that run afoul of the upper payment limit and whether any further action is needed. It is a significant effort being undertaken.

Ms. DUCKWORTH. If you applied to the past, would the upper payment limit program you are initiating now have identified payments such as those run by the New York Office of People with Developmental Disabilities, would it have caught those?

Ms. MANN. It would have. I might add the State shares responsibility with the Federal Government to assure that it follows federal law. The State did certify for years that it was following the upper payment limit and its payments were within the limit. The limit was not imposed in the last couple of years.

We did not review that annually. We relied on their certification and only reviewed it when they made a change which they didn't make for many years. Now the annual demonstration of the upper payment limit to us gives us an additional tool in addition to what the State has before them to make sure these kinds of payments would not happen again.

Ms. DUCKWORTH. Ms. Iritani, was that the kind of thing that would be helpful in our earlier discussion talking about greater reporting and greater transparency? Would a process like this be helpful in providing the oversight?

Ms. IRITANI. We think the initiative Ms. Mann discussed is a good step. However, we feel there are still significant gaps in their oversight. In the particular case of the hospitals we identified receiving the very high payments, we looked at the UPL demonstration and the hospitals that had received these high payments. The payment amounts they were receiving were not identified.

We looked at other documentation the State submitted to CMS around that payment arrangement and none of the documentation actually identified the actual payments those facilities received.

Ms. DUCKWORTH. I certainly would welcome more oversight. I just want to make sure that we continue to provide services to persons with disabilities and other vulnerable groups. Thank you very much.

I yield back, Mr. Chairman.

Ms. SPEIER. Mr. Chairman, if I may. Ms. Iritani, based on what my colleague, Ms. Duckworth, has said, it sounds like we still have a way to go to create that kind of transparency that is necessary.

I don't want a lot of happy talk here at the end where we think we have made all this advancement and in fact, we are just kind of nibbling around the edges. What more should be done by CMS to make sure that we are addressing the gaps and creating meaningful transparency?

Ms. IRITANI. On the payment side, CMS needs to know how much providers are actually getting paid. Without having supplemental payment data, they cannot know that. The current mechanisms they have for approving payments such as the one with the hospitals are not identifying the actual payments individual facilities are being paid.

On the financing side, CMS' oversight is also not identifying the extent that individual facilities are contributing the non-federal share and with the flexibility under federal rules, States can ask individual facilities to fund all of the non-federal share of a payment which effectively reduces the facility's payment significantly.

From the provider's perspective, the net payment is what they are receiving.

Mr. LANKFORD. Can you go into greater detail on that last statement? How does that work?

Ms. IRITANI. The 60–40 requirement in terms of the State being required to contribute 40 percent is applied in the aggregate, not for individual payment arrangements. It allows States to concentrate a requirement, for example, through an intergovernmental transfer on a particular facility to provide all of the non-federal share.

This is part of what creates the incentive for States to over pay individual facilities that are financing the non-federal share.

Mr. LANKFORD. How would do that and why would a facility say let us do the bulk of the payment? That is not natural, I would say, for a facility to say, we would like to pay the majority of this tax. Why would they do that?

Ms. IRITANI. I think there could be arrangements where they are receiving what might be considered excessive payments. From the standpoint of the providers, they understand the State needs to provide the non-federal share, so they are either being required to contribute or are voluntarily doing so.

Mr. LANKFORD. Can you provide us any examples with that?

Ms. IRITANI. For example, the two hospitals we identified in our statement that were receiving the $8,800 per day estimated payment from Medicaid, those providers were also financing the non-federal share of those payments.

When you consider the match rate for New York, that would reduce the payments they were receiving considering the net payments less the non-federal share they were receiving. We still think that even if you cut that $8,800 per day in half it is still much higher than what local government hospitals in the city were receiving.

Mr. LANKFORD. For those facilities, they were paying a much higher rate and the provider tax basically the share that needs to come in from the non-federal entity but they are also being paid a much higher rate when actually they are being paid for their services?

Ms. IRITANI. Exactly. That is how the cost shifting can occur.

Mr. LANKFORD. Ms. Mann, do you want to comment on that?

Ms. MANN. Thank you. Again, we would totally agree with the recommendation for greater transparency. I just want to make sure that everyone is clear that the steps that have been taken are significant.

Overall, these payments are within what is called the upper payment limit established by Congress by classes. The classes that were established divide public providers, State providers and local providers to try and address some of these financing issues.

That upper payment limit assures that in the aggregate the payments to that class of providers can be no more than the cost.

Mr. LANKFORD. But an individual hospital may get a much, much higher rate?

Ms. MANN. That is right and as we noted before, not saying anything about the validity of this particular payment because we need to look at it more closely, these hospitals were not getting dis-

proportionate share payments and they were specialty hospitals within the New York City health and hospital system.

There may be different things going on that we will want to look at but within the context in terms of the exposure of potentially excess payments, it is within an overall aggregate cost structure. To the extent they are getting those payments, other providers within those classes are not.

Mr. LANKFORD. Right. To the extent of that these two hospitals received about ten times more in that supplemental than my state did in total for DSH payments. I would say they were an outlier to say the least and may need some further examination.

I have a question and a statement. I don't know if anyone else has additional questions. GAO, there is a sentence in your report that I want to follow up and get greater detail on. "CMS has taken steps to improve the transparency and oversight of Medicaid financing and payments but has not implemented all of GAO's prior recommendations and has generally disagreed with GAO's new recommendation." What is the new recommendation you are referencing there?

Ms. IRITANI. The new recommendation is that CMS develop a data collection strategy for improving the completeness and accuracy of data that they have on how States are financing the non-federal share.

Mr. LANKFORD. Is it accurate to say you disagree with that or is that something you are in the process of implementing?

Ms. MANN. First of all, the recommendations on the supplemental payments and public reporting of that is a new recommendation that has not yet been shared with us. It was just announced at this testimony. I believe we fully agree with that.

The particular recommendation before was on whether we should do public reporting of financing of each facility's payment. We think it is probably more helpful to have public reporting of the supplemental payments to the facilities and then overall, the State's use of distribution of non-federal share of dollars.

It was more the particular proposal and using a particular data set that we thought was not exactly right, certainly not in the spirit of making sure that there is good information about both the non-federal share financing and certainly the actual payments themselves.

Mr. LANKFORD. The difficulty is are we getting accurate, matchable data that we can actually line up what is happening in individual locations with what is being paid so we know what a provider is being paid.

Ms. MANN. That is right. We totally agree with that.

Mr. LANKFORD. When is that coming so that we know that?

Ms. MANN. We will be working on that and we will be in communication with the committee about that.

Ms. IRITANI. Mr. Chairman, may I respond?

Mr. LANKFORD. Yes.

Ms. IRITANI. The recommendation we have to improve facility specific reporting of Medicaid payments has been in place for many years. That was made to CMS in a report. I don't have the date right now but it has been many years.

Mr. LANKFORD. Not necessarily public reporting of that but it is available to CMS to be able to access that data?

Ms. IRITANI. Correct. Our work on Medicaid payments to government providers is ongoing. We expect a report by the end of the year. We do not have recommendations yet.

Mr. LANKFORD. Additional comments? Let me drop my one bombshell since it has been referenced several times and on the dais as well. It is the comment about block granting which several folks have talked about.

Much of what we have talked about today is transparency of information coming back to the Federal Government. If there comes a day that we identify to a State whether it be a pilot program or whatever it may be, this State is given the ability to be able to manage its people, we are not having to play the provider share game and who is doing the provider attacks and what municipality.

They have the amount of money they are getting right now attached to that State and the responsibility to be able to take care of their people in that State.

Most of the issues we talked about today go away because much of the fight is how much information are we getting from States and other people. They simply have the responsibility in their State which I would assume States are doing anyway, doing whatever they can.

The Medicaid leadership in each State comprises some pretty amazing people scattered around the Country trying to do some very hard work to be able to manage people in their State of great need and who are very, very vulnerable.

I know this is an ongoing conversation today about transparency. I wanted to be able to mention the block granting concept in the days ahead because it has come up several times in this conversation. Much of what we talked about being high risk is reporting requirements that all go away and we move from reporting requirements to taking care of people as the first and primary priority there.

Ms. Mann, why do I think you might disagree with that?

Ms. MANN. A couple of things. I totally agree with we should be moving to more outcome based measurement of performance of our program. That is something we have been working with and something I think States totally agree with. I fully agree with that.

I guess where I would disagree is that what we are worrying about here, which I think is not the norm. I think you are absolutely right, Medicaid programs are run well. Hard working people are running them trying to deliver good services to people who need those services.

To the extent that we worry about State use of those federal dollars and arrangements with providers, block granting those dollars and saying we have no responsibility over those dollars seems to me to exacerbate the legitimate concerns we think the committee has around ensuring always we have sound financial management.

If there is need for more financial management, the answer is not to have less.

Mr. LANKFORD. I just have the belief that there are people in individual States that actually care for their people, not just the people in Washington, D.C.

Ms. MANN. I totally agree.

Mr. LANKFORD. I think there is a way to be able to do financial transparency of how it is being spent but understanding the care in the decision making, the waivers that have come up multiple times today if those move through a State happen much faster and the capability to be able to experiment with how you deliver quality care to even more people happens at a faster rate when it is made on a local level.

When it is done here in Washington, D.C., they are numbers on a page because there is no way to be able to manage it. It is the same hearing we have had here multiple times. There is such a high rate, as we mentioned, not necessarily fraud but it is money we don't know about, and they haven't completed all the paperwork, all the signatures aren't there.

It is difficult to do for 50 States and 50 processes. It is much different to do in an individual State.

I know I have taken us off track but I wanted to bring that up at the end.

I thank you for your testimony. I thank you for bringing the additional written documents. We look forward to some follow up questions and getting additional data.

With that, we are adjourned.

[Whereupon, at 12:00 p.m., the subcommittee was adjourned.]

APPENDIX

MATERIAL SUBMITTED FOR THE HEARING RECORD

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL
WASHINGTON, DC 20201

JUL 21 2014

The Honorable Darrell Issa
Chairman
Committee on Oversight and Government Reform
House of Representatives
Washington, DC 20515

The Honorable Jim Jordan
Chairman
Subcommittee on Economic Growth,
Job Creation and Regulatory Affairs
Committee on Oversight and Government Reform
House of Representatives
Washington, DC 20515

The Honorable James Lankford
Chairman
Subcommittee on Energy Policy,
Health Care and Entitlements
Committee on Oversight and
Government Reform
House of Representatives
Washington, DC 20515

Dear Chairman Issa, Chairman Lankford, and Chairman Jordan:

I am writing as a follow up to your July 1, 2013, letter in which you asked the U.S. Department of Health and Human Services, Office of Inspector General (OIG), to undertake audit work involving New York's Medicaid program. Your letter described a number of specific areas susceptible to abuse where you asked us to focus our audit attention.

In response to your request, OIG consulted with Committee staffer Brian Blase and, in a letter to the Committee on Oversight and Government Reform, dated September 10, 2013, agreed to perform the following:

(1) Audits of providers that are susceptible to fraud, waste, and abuse.

(2) Work related to Medicaid payments to managed care organizations.

(3) Additional audits of payment rates for State-operated facilities.

(4) Audits in other areas or issues that we determine to be vulnerable to inappropriate claims for Federal funding.

As of July 3, 2014, OIG has issued seven audit reports identifying $150 million in questioned costs and $346 million in potential annual cost savings. One audit of Medicaid payments to managed care organizations in New York is ongoing. Details of our work are provided in the enclosure.

Should you have any questions regarding the results of these audits, please contact me or your staff may contact Chris Hinkle, Director of Congressional Regulatory Affairs, at 202-401-2206 or Christina.Hinkle@oig.hhs.gov.

Sincerely,

Daniel R. Levinson

Daniel R. Levinson
Inspector General

Enclosure

ENCLOSURE: DETAILS OF THE OFFICE OF INSPECTOR GENERAL AUDIT WORK ON THE NEW YORK MEDICAID PROGRAM

PROVIDERS THAT ARE SUSCEPTIBLE TO FRAUD, WASTE, AND ABUSE

New York State Improperly Claimed Medicaid Reimbursement for Some Home Health Services Claims Submitted by Certified Home Health Agencies (A-02-11-01008)[1]

The New York State Department of Health (State agency) claimed Federal Medicaid reimbursement for some home health services claims submitted by Certified Home Health Agencies (CHHAs) in the State that were not in accordance with Federal and State requirements. On the basis of our sample results, we estimated that the State agency improperly claimed at least $31.5 million in Federal Medicaid reimbursement. These deficiencies occurred because some CHHAs in the State did not comply with Federal and State requirements.

We recommended that the State agency (1) refund $31.5 million to the Federal Government and (2) issue guidance to CHHAs in the State on Federal and State requirements for physicians' orders and plans of care. The State agency did not indicate either concurrence or nonconcurrence with our recommendations.

New York Improperly Claimed Medicaid Reimbursement for Orthodontic Services to Beneficiaries in New York City (A-02-11-01003)[2]

The State agency claimed Federal Medicaid reimbursement for orthodontic services provided to beneficiaries in New York City that did not always comply with Federal and State requirements. On the basis of our sample results, we estimated that the State agency claimed at least $7.8 million in unallowable Federal reimbursement.

These deficiencies occurred because the State agency and providers did not ensure that cases were reviewed annually to determine the need for continuing care and that services were documented. Further, the State agency provided limited guidance to providers on State regulations requiring orthodontic care to be reviewed annually to determine the need for continuing care. Finally, the State agency did not (1) sufficiently educate providers regarding their responsibilities to ensure that their patients receive annual clinical reviews at screening centers and (2) maintain adequate documentation.

We recommended that the State agency (1) refund $7.8 million to the Federal Government and (2) strengthen guidance and provider education activities related to authorizing continuing treatment and maintaining adequate documentation. The State agency did not indicate concurrence or nonconcurrence with either of our recommendations.

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[1] http://oig.hhs.gov/oas/reports/region2/21101008.asp.

[2] http://oig.hhs.gov/oas/reports/region2/21101003.asp.

MEDICAID PAYMENTS TO MANAGED CARE ORGANIZATIONS

New York State Made Unallowable Medicaid Fee-for-Service Payments for Beneficiaries Also Enrolled in Medicaid Managed Care (A-02-12-01007)[3]

The State agency did not prevent separate Medicaid fee-for-service payments from being made for beneficiaries also enrolled in a Medicaid managed care organization. Specifically, for all 107 inpatient admissions included in our sample, the State agency improperly claimed Federal Medicaid fee-for-service reimbursement for inpatient hospital services on behalf of beneficiaries for whom separate Medicaid managed care payments were made under a different Medicaid identification number. These improper payments occurred because the State agency operated two eligibility systems that did not identify beneficiaries with multiple Medicaid identification numbers. In addition, local departments of social services did not use all available resources within the systems to ensure that beneficiaries were not issued multiple Medicaid identification numbers.

On the basis of our sample results, we estimated that the State agency improperly claimed at least $23.4 million in Federal Medicaid fee-for-service reimbursement for inpatient hospital services made on behalf of beneficiaries for whom separate Medicaid managed care payments were also made.

We recommended that the State agency (1) refund $23.4 million to the Federal Government and (2) use all available resources to ensure that no beneficiary is issued multiple Medicaid identification numbers or develop one eligibility system that could be used to determine whether applicants are enrolled in any medical or public assistance program throughout New York State. The State agency partially agreed with our first recommendation and generally agreed with our second recommendation.

Medical Loss Ratios

We are determining the potential Medicaid program savings if Medicaid managed care plans were required to meet the standards in the medical loss ratio (MLR) provision of the Affordable Care Act. Using data obtained from the State, we performed preliminary calculations of the MLRs for New York's managed care plans with Medicaid contracts during calendar year 2012. From these calculations, we selected 10 mainstream and 10 long-term managed care plans[4] for further analysis and are performing an ongoing detailed review of these plans' MLRs. As stated in previous conversations with Committee staffer Brian Blase, this work will likely be completed in late 2014.

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[3] http://oig.hhs.gov/oas/reports/region2/21201007.asp.

[4] Most, but not all, Medicaid beneficiaries in New York State who do not have Medicare must join a "mainstream" Medicaid managed care plan. In Medicaid managed care, an enrollee can only see the doctors and other health providers in his or her plan's network and must follow the plan's rules for accessing care. In addition, the enrollee is assigned a primary care provider and must go to this provider to get a referral for specialty care and prior authorizations for nonemergency hospitalizations and many other services.

PAYMENT RATES FOR STATE-OPERATED FACILITIES

Medicaid Rates for Residential Habilitation Services Provided at New York State-Operated Residences Are Excessive (A-02-13-01008)[5]

The payment rates for residential habilitation services provided at State-operated residences did not meet the Federal requirement that payment for services be consistent with efficiency and economy. Specifically, for State fiscal year 2010, Federal Medicaid payments exceeded actual costs for providing these services by approximately $320 million (57 percent more than actual costs). Further, the payment rate for supervised residential habilitation services at State-operated residences was more than double the average rate for privately operated residences that offered the same services.

We also determined that if the State agency had used the prior year's actual costs to calculate payment rates for residential habilitation services, its State fiscal year 2011 total reimbursement would have been approximately $692 million ($346 million Federal share) less than what it claimed and may result in similar savings annually.

Payment rates for residential habilitation services were significantly higher because the Centers for Medicare & Medicaid Services (CMS) did not adequately consider the appropriateness of the New York State Office for People With Developmental Disabilities' (OPWDD) rate-setting methodology when it approved New York's waiver agreement. Specifically, CMS approved DOH's application for its waiver even though the application did not describe in detail the methodology that DOH used to calculate payment rates for State-operated residences. According to New York officials, that methodology used the prior year's adjusted payment rates, which were calculated using reimbursable costs rather than actual costs, to determine payment rates for the current year.

We recommended that CMS work with New York to ensure that the methodology used to set payment rates for State-operated residences meets the Federal requirement that payment for services be consistent with efficiency and economy. The State agency stated that it, along with OPWDD, has taken aggressive actions to address the issues we raised. CMS concurred with our recommendation.

[5] http://oig.hhs.gov/oas/reports/region2/21301008.asp.

OTHER AREAS VULNERABLE TO INAPPROPRIATE CLAIMS FOR FEDERAL FUNDING

New York Claimed Hospital-Based Continuing Day Treatment Services That Were Not in Compliance With Federal and State Requirements (A-02-11-01038)[6]

In this, our first issued review on continuing day treatment (CDT) providers, the State agency claimed Federal Medicaid reimbursement for CDT services rendered by hospital-based providers that were not in accordance with Federal and State requirements. On the basis of our sample results, we estimated that the State agency improperly claimed at least $8.3 million in Federal Medicaid reimbursement.

The deficiencies identified in the report occurred because (1) certain hospital-based CDT providers did not comply with Federal and State requirements and (2) the State agency did not ensure that the New York State Office of Mental Health (OMH) adequately monitored the CDT program for compliance with certain Federal and State requirements.

We recommended that the State agency (1) refund $8.3 million to the Federal Government, (2) work with OMH to issue guidance to the hospital-based provider community regarding Federal and State requirements for claiming Medicaid reimbursement for CDT services, and (3) work with OMH to improve OMH's monitoring of the CDT program to ensure compliance with Federal and State requirements. The State agency disagreed with our first recommendation and did not indicate concurrence or nonconcurrence with our remaining recommendations.

New York Claimed Nonhospital Continuing Day Treatment Services That Were Not in Accordance With Federal and State Requirements (A-02-12-01011)[7]

In this, our second review on CDT providers, the State agency claimed Federal Medicaid reimbursement for CDT services provided by nonhospital providers that were not in accordance with Federal and State requirements. On the basis of our sample results, we estimated that the State agency improperly claimed at least $18.1 million in Federal Medicaid reimbursement.

The deficiencies identified in the report occurred because (1) certain nonhospital CDT providers did not comply with Federal and State regulations and (2) the State agency did not ensure that OMH adequately monitored the CDT program for compliance with certain Federal and State requirements.

We recommended that the State agency (1) refund $18.1 million to the Federal Government, (2) work with OMH to issue guidance to the provider community regarding Federal and State requirements for claiming Medicaid reimbursement for nonhospital CDT services, and (3) work with OMH to improve OMH's monitoring of the CDT program to ensure compliance with

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[6] http://oig.hhs.gov/oas/reports/region2/21101038.asp.

[7] http://oig.hhs.gov/oas/reports/region2/21201011.asp.

Federal and State requirements. The State agency disagreed with our first recommendation and did not indicate concurrence or nonconcurrence with our remaining recommendations.

New York Claimed Unallowable Room-and-Board Costs Under Its Developmental Disabilities Waiver Program (A-02-12-01031)[8]

The State agency claimed Federal Medicaid reimbursement for unallowable room-and-board costs for residential habilitation services provided at State-operated residences under New York's developmental disabilities waiver program. Specifically, certain unallowable room-and-board costs, such as repairs, maintenance, utilities, and property-related costs, were included in the indirect costs used to calculate the residential habilitation services payment rates. As a result, the State agency claimed $60.8 million (Federal share) in unallowable Medicaid reimbursement.

We recommended that the State agency (1) refund $60.8 million to the Federal Government and (2) ensure that OPWDD excludes all unallowable room-and-board costs from indirect costs used in payment rate calculations for residential habilitation services. The State agency disagreed with our first recommendation and did not indicate concurrence or nonconcurrence with our second recommendation.

[8] http://oig.hhs.gov/oas/reports/region2/21201031.asp.

United States Government Accountability Office

GAO

Report to Congressional Requesters

July 2014

MEDICAID FINANCING

States' Increased Reliance on Funds from Health Care Providers and Local Governments Warrants Improved CMS Data Collection

GAO-14-627

GAO Highlights

Highlights of GAO-14-627, a report to congressional requesters

July 2014

MEDICAID FINANCING

States' Increased Reliance on Funds from Health Care Providers and Local Governments Warrants Improved CMS Data Collection

Why GAO Did This Study

Medicaid, a jointly financed federal-state program, cost $432 billion in 2012. States use various sources of funds to finance the nonfederal share, such as state funds and funds from health care providers and local governments. Concerns have been raised about increased Medicaid payments that are financed with funds from providers receiving the Medicaid payments. Although such financing arrangements are allowed under certain conditions, they can also result in shifting costs to the federal government with limited benefits to providers and beneficiaries.

GAO was asked to review states' financing of the nonfederal share of Medicaid. GAO examined the extent to which (1) states have relied on funds from health care providers and local governments to finance the nonfederal share; (2) this reliance has changed in recent years, and any implications of changes; and (3) CMS collects data to oversee states' sources of funds. GAO administered a questionnaire to all state Medicaid agencies, examined effects of financing changes in a nongeneralizable sample of three states selected in part based on Medicaid spending and geographic diversity, and met with CMS officials.

What GAO Recommends

GAO recommends that CMS take steps to ensure states report accurate and complete data on all sources of funds to finance the nonfederal share. CMS did not concur with GAO's recommendation but stated that it will examine efforts to improve data collection for oversight. As discussed in the report, GAO believes its recommendation is valid.

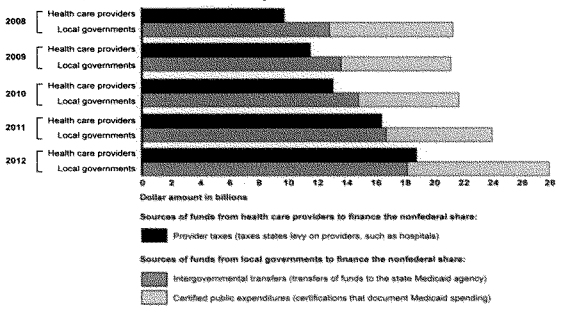
View GAO-14-627. For more information, contact Katherine M. Iritani at (202) 512-7114 or iritanik@gao.gov.

What GAO Found

GAO found, based on a questionnaire sent to state Medicaid agencies, that states financed 26 percent, or over $46 billion, of the nonfederal share of Medicaid expenditures with funds from health care providers and local governments in state fiscal year 2012. State funds were most of the remaining nonfederal share.

Nationally, states increasingly relied on funds from providers and local governments in recent years to finance the nonfederal share, based on GAO's analysis (see figure). In the three selected states this increase resulted in cost shifts to the federal government. While the total amount of funds from all sources, including state funds, increased during state fiscal years 2008 through 2012, funds from providers and local governments increased as a percentage of the nonfederal share, while state funds decreased. GAO's review of selected financing arrangements in California, Illinois, and New York illustrates how the use of funds from providers and local governments can shift costs to the federal government. For example, in Illinois, a $220 million payment increase for nursing facilities funded by a tax on nursing facilities resulted in an estimated $110 million increase in federal matching funds and no increase in state general funds, and a net payment increase to the facilities, after paying the taxes, of $105 million.

Amount of the Nonfederal Share of Medicaid Payments from Health Care Providers and Local Governments, State Fiscal Years 2008 through 2012



Source: GAO. | GAO-14-627

The Centers for Medicare & Medicaid Services (CMS)—the federal agency that oversees Medicaid—has not ensured the data on state Medicaid financing are accurate and complete, and while new initiatives to improve reporting have begun, data gaps remain. More reliable data to effectively monitor the program would allow CMS and others to identify net provider payments and assess the effects of the payments on providers, beneficiaries, and the federal government. GAO has found that as currently designed, two CMS initiatives to improve data collection have data gaps that will limit their effectiveness for CMS's oversight.

Contents

Abbreviations

CMS	Centers for Medicare & Medicaid Services
CPE	certified public expenditure
DSH	Disproportionate Share Hospital
FMAP	federal medical assistance percentage
HCFA	Health Care Financing Administration
IGT	intergovernmental transfer
MACPAC	Medicaid and CHIP Payment and Access Commission
Recovery Act	American Recovery and Reinvestment Act of 2009
T-MSIS	Transformed Medicaid Statistical Information System
UPL	Upper Payment Limit

GAO U.S. GOVERNMENT ACCOUNTABILITY OFFICE
441 G St. N.W.
Washington, DC 20548

July 29, 2014

The Honorable Darrell E. Issa
Chairman
Committee on Oversight and Government Reform
House of Representatives

The Honorable James Lankford
Chairman
Subcommittee on Energy Policy, Health Care and Entitlements,
Committee on Oversight and Government Reform
House of Representatives

The Medicaid program involves significant and growing expenditures for the federal government and states, and states have used various sources of funds to help finance their share of the program.[1] In 2012, Medicaid provided health care coverage for 58 million low-income individuals at a cost of $432 billion.[2] The federal government matches each state's Medicaid expenditures for services according to a state's federal medical assistance percentage (FMAP).[3] On average, the federal share of Medicaid service expenditures is about 57 percent. States finance the nonfederal share in large part through state general funds and depend on other sources of funds, such as taxes on health care providers and funds from local governments, to finance the remainder. In accordance with federal requirements, states have the flexibility to set payment rates for covered services and generally administer the Medicaid program, subject to the approval and oversight of the Centers for Medicare & Medicaid Services (CMS).

[1]For purposes of this report, sources of funds are the means (e.g., taxes) by which funds are supplied by entities (e.g., providers) to the state to be used to finance the nonfederal share of Medicaid; we do not use the term to refer to the entities themselves.

[2]See Department of Health and Human Services, *2013 Actuarial Report on the Financial Outlook for Medicaid* (Washington, D.C.: 2013).The number of individuals covered is the average enrollment over the course of the year.

[3]The FMAP is based on a formula established by law under which the federal share of a state's Medicaid expenditures for services generally may range from 50 to 83 percent. States with lower per capita income receive a higher FMAP for services.

Our past work has found that flexibility in federal requirements regarding states' calculations of Medicaid provider payments and financing of the nonfederal share has enabled states to create various financing arrangements that have affected the share supplied by the federal and state governments and the amounts paid to providers.[4] Although these types of arrangements are permissible under certain conditions, they have resulted in states being able to maximize federal matching funds and rely less on state general funds. Specifically, states have been able to shift large shares of Medicaid costs to health care providers[5] and local governments by taxing health care providers or by requiring local governments to supply funds to be used for Medicaid payments.[6] In addition, states have made large supplemental payments—payments that are separate from the regular payments states make based on claims submitted for services rendered—to providers that supplied funds to finance the nonfederal share of the payments, for purposes of obtaining billions of dollars in additional federal matching funds without a commensurate increase in state funds used to finance the nonfederal share of these Medicaid expenditures. Such arrangements have the effect of shifting costs to the federal government because the federal government then pays its share of the new payments.

We and others have raised concerns about these financing arrangements and whether data reported by states are sufficient for CMS to determine that these arrangements are in compliance with applicable federal requirements.[7] CMS plays an important role in ensuring the fiscal integrity of Medicaid. Its responsibilities include ensuring that federal Medicaid matching funds are provided for eligible expenditures and that the federal

[4]A list of related GAO products appears at the end of this report.

[5]For purposes of this report, health care providers include both private providers, such as hospitals and nursing homes, that serve Medicaid beneficiaries and state- or county-owned or -operated providers, including hospitals and nursing homes.

[6]Local government funds can come from local government entities, such as counties, cities, and local hospital districts, as well as directly from local-government-owned or -operated providers, such as county hospitals. For purposes of this report, local government refers to both local government entities and local-government-owned or -operated providers.

[7]See Medicaid and CHIP Payment and Access Commission, *Report to the Congress on Medicaid and CHIP* (Washington, D.C.: March 2014). See GAO, *Medicaid: More Transparency of and Accountability for Supplemental Payments Are Needed*, GAO-13-48 (Washington, D.C.: Nov. 26, 2012).

government and states share in the financing of the Medicaid program as established by law. But we have reported that CMS has lacked data on large Medicaid payments made to government providers and on financing arrangements states have used for these Medicaid payments.[8] Supplemental payments totaled at least $43 billion in federal fiscal year 2011, up from $32 billion federal fiscal year 2010 and at least $23 billion in federal fiscal year 2006. Because supplemental payments are typically not paid through states' Medicaid claims systems, the payments are not captured in federal data systems and therefore lack transparency for oversight purposes.[9] In 2003, we designated Medicaid as a high-risk program, in part because of concerns related to oversight of these Medicaid payment and financing arrangements.[10]

You asked us to study how states are financing the nonfederal share of their Medicaid programs and whether states' financing has changed in recent years. This report provides information on (1) the extent to which states have relied on funds from health care providers and local governments to finance the nonfederal share of Medicaid; (2) the extent to which states have changed their reliance on health care providers and local governments to help finance the nonfederal share of Medicaid in recent years, and implications, if any, of these changes; and (3) the extent to which CMS collects data to oversee states' use of various sources of funds.

To determine the extent to which states have relied on funds from health care providers and local governments to finance the nonfederal share of Medicaid, we sent a questionnaire to all states and the District of Columbia.[11] We fielded the questionnaire from July 2013 through November 2013 and received responses from all states. The questionnaire collected information on each state's use of funds from health care providers and local governments, state general funds, and

[8]See GAO-13-48 and GAO, *Medicaid: Improved Federal Oversight of State Financing Schemes Is Needed*, GAO-04-228 (Washington, D.C.: Feb. 13, 2004).

[9]Since 2010 CMS has required states to report supplemental payments when reporting quarterly expenditures for purposes of claiming federal Medicaid matching funds; however, payments are reported in the aggregate and not on a provider-specific basis.

[10]See GAO, *High Risk Series: An Update*, GAO-13-283 (Washington, D.C.: February 2013).

[11]For purposes of this report, "states" refers to the 50 states and the District of Columbia.

other sources to finance the nonfederal share of Medicaid from state fiscal year 2008 through state fiscal year 2012, and the type of Medicaid payments—for example, regular or supplemental—to which the funds were applied.[12] States reported both actual amounts and estimated amounts based on the information available to them.[13] We did not independently verify the data reported by states in the questionnaire; however, we reviewed published data submitted by state Medicaid programs to CMS and to outside researchers to assess the reasonableness of the data reported. We believe the data are reliable for our purposes. Assessing whether states were compliant with federal requirements related to nonfederal sources of funds for Medicaid payments was not within the scope of this review.

To determine the extent to which states have changed their reliance on funds from health care providers and local governments to help finance the nonfederal share of Medicaid in recent years, and what the implications have been, if any, of these changes, we analyzed questionnaire responses and obtained more in-depth information on any implications of changes in reliance on funds from health care providers and local governments from a nongeneralizable sample of three states. These states—California, Illinois, and New York—were selected on the basis of having large Medicaid programs, based on spending for Medicaid services; making large amounts of certain supplemental payments to providers; having made changes in sources of funds to finance the nonfederal share and in Medicaid payment rates from 2008 through 2011; and geographic diversity. In these three states, we obtained and analyzed Medicaid payment data from before and after an increase in funds from health care providers or local governments that occurred during state fiscal years 2008 through 2012 to determine the effect of the change on the amounts of Medicaid payments states made to providers and on the

[12]For purposes of this report, state funds refers to state general funds and intra-agency funds, which are intra-agency payments, intra-agency transfers, and intra-agency certified public expenditures. Other sources of funds include tobacco settlement funds and state trust funds. Taxes on health care services, or the provision or payment for these services, are being reported separately as health care provider taxes.

States' fiscal years are set by states and do not necessarily align with the federal fiscal year. Most state fiscal years start July 1 and end June 30.

[13]States were asked to report sources of funds used to finance the nonfederal share of four types of Medicaid payments. See app. I for information about the four types of Medicaid payments.

amounts of state general funds, funds from local governments, and federal funds used to finance these payments. We also conducted interviews with Medicaid department officials in these states. (See app. I for more detail on the scope and methodology used to determine the extent to which states have relied on funds from health care providers and local government to finance the nonfederal share of Medicaid and to select the nongeneralizable sample of three states.) We also interviewed CMS officials, including representatives from regional offices, regarding states' use of various sources of funds to finance the nonfederal share of Medicaid and CMS oversight. Assessing whether sources of funds, such as provider taxes, complied with applicable federal requirements was not within the scope of our review. We determined that the questionnaire responses states provided were sufficiently reliable for our purposes by contacting state Medicaid department officials and clarifying conflicting, unclear, or incomplete information. We determined that the data from California, Illinois, and New York were sufficiently reliable for our purposes by checking the data for discrepancies and omissions and interviewing state officials to resolve any identified discrepancies. Findings from these three states are not generalizable to other states.

To determine the extent to which CMS collects data to oversee states' use of various sources of funds, we asked CMS officials about the data they collect, the reliability of the data, and their oversight of state financing of the nonfederal share. We also reviewed relevant federal laws, regulations, and guidance. As discussed in the report, we identified a number of concerns with the accuracy and completeness of CMS's data.

We conducted this performance audit from January 2013 to July 2014 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

Within broad federal requirements under Title XIX of the Social Security Act, each state administers and operates its Medicaid program in accordance with a state Medicaid plan, which must be approved by CMS. A state Medicaid plan describes the groups of individuals to be covered; the methods for calculating payments to providers, including which types of providers are eligible to receive payments; and the categories of

services covered, such as inpatient hospital services, nursing facility services, and physician services. Any changes a state wishes to make in its Medicaid plan, such as establishing new Medicaid payments to providers or changing methodologies for payment rates for services, must be submitted to CMS for review and approval as a state plan amendment. CMS informs states about Medicaid program requirements through federal regulations, a published State Medicaid Manual, standard letters issued to all state Medicaid directors, and technical guidance manuals on particular topics.

Federal Funds and State Medicaid Payments

To obtain federal matching funds for their Medicaid payments to providers, states submit their estimated payments to CMS each quarter for an upcoming quarter. After CMS has approved the estimate, it makes federal matching funds available to the state for the purpose of making Medicaid payments during the quarter. States typically make Medicaid payments to providers with a combination of nonfederal funds and federal funds. After each quarter, states submit a quarterly payment report.[14]

Federal matching funds are available to states for different types of payments that states make, including payments directly to providers for services rendered, capitation payments to managed care organizations,[15] and supplemental payments. States make payments directly to providers under a fee-for-service delivery system. Providers render services to beneficiaries and then submit bills to the state to receive payment; states pay the providers based on established payment rates for the services provided. States also make capitation payments to managed care organizations that contract with the state to provide or arrange for medical services for Medicaid beneficiaries enrolled with the managed care organization. States make payments to managed care organizations, and the organizations pay the providers. Most states use both fee-for-service and managed care delivery systems, with some beneficiaries receiving services through fee-for-service and other beneficiaries receiving services through managed care. Supplemental payments are generally made

[14]CMS reconciles the amount of federal funds advanced to the state at the beginning of the quarter with the amount of federal funds claimed for payments made during the quarter to finalize the federal funding provided to the state. This results in a reconciliation adjustment to finalize the federal reimbursement to the state for the quarter.

[15]A capitation payment is a fixed monthly payment per enrollee that a state prospectively pays to a managed care organization.

monthly, quarterly, or annually as lump sum payments. States have some flexibility in determining to whom they make supplemental payments. Supplemental payments include Disproportionate Share Hospital (DSH) payments, which states are required by federal law to make to hospitals that serve large numbers of Medicaid and uninsured low-income individuals. Many states also make other supplemental payments that are not required under federal law. For purposes of this report, we refer to these payments as non-DSH supplemental payments. These payments include Medicaid Upper Payment Limit (UPL) supplemental payments[16] and payments made to hospitals and other providers authorized under Medicaid demonstrations.[17]

Nonfederal Sources of Funds for State Medicaid Payments

States have a significant amount of flexibility in determining which sources of funds to use to finance their nonfederal share, although federal law does impose certain limits on the financing of overall Medicaid expenditures. For example, states must use state funds to finance at least 40 percent of the nonfederal share of total Medicaid expenditures each year. States finance the nonfederal share primarily with state funds, particularly state general funds appropriated directly to the state Medicaid agency, but also with intra-agency funds, whereby other state agencies that receive state appropriations, such as state mental health agencies, supply funds to finance the nonfederal share of Medicaid services they may provide. States may also receive funds to finance the nonfederal share of Medicaid payments from health care providers, such as hospitals or nursing facilities, and local governments, including government-owned or -operated providers. Health care providers and local governments can

[16]UPL payments are Medicaid payments that are above the standard Medicaid payment rates, but within the upper payment limit, defined as the estimated amount that Medicare would pay for comparable services. This limit is not applied to payments to individual providers and instead applies to payments to all providers rendering specific services within an ownership class, such as state government-owned or -operated facilities that provide inpatient services. Although these payments generally do not have a specified statutory or regulatory purpose, they must be made for allowable Medicaid expenditures and must comply with applicable federal requirements, such as being economical, efficient and ensuring access to care.

[17]Under section 1115 of the Social Security Act, states may apply to and receive approval from CMS for a demonstration that allows states to deviate from their traditional Medicaid programs. Authorities under the demonstrations provide states with the ability to claim Medicaid funds for new types of expenditures, including the costs of making additional payments to providers from funding pools authorized under such demonstrations.

supply funds to be used to finance the nonfederal share through several sources. For example:

- A state may levy taxes on health care providers to generate revenues to finance the nonfederal share of Medicaid payments.[18] Provider taxes are typically imposed on private health care providers. States may tax a wide range of services, and health care providers may be subject to more than one tax during a year.[19] In addition, states may receive donations from providers. Generally, provider taxes and donations produce revenues that flow into state treasuries and are then directly appropriated to the state Medicaid agency.
- A state may obtain funds from local governments (e.g., counties or cities), or from hospitals or other providers that are owned or operated by local governments, via fund transfers to the state—known as intergovernmental transfers (IGT)—that can be used to finance the nonfederal share of Medicaid payments. Under agency policy, CMS requires that IGTs occur before the state makes a Medicaid payment to the provider and that the amount of the transfer cannot be greater than the nonfederal share of the Medicaid payment amount. CMS took this action to curtail states' ability to claim federal matching funds on large Medicaid payments made to certain government providers that were then returned to the state in the form of IGTs.
- A state may obtain funds from local governments (e.g., counties or cities), or from hospitals or other providers that are owned or operated by local governments, via certifications of spending—known as certified public expenditures (CPE)—that can be used to document state Medicaid spending in order to obtain federal matching funds. CPEs do not involve the transfer of money to be used to finance the nonfederal share; rather, the local government provider or entity certifies to the state an amount that it has expended for Medicaid-covered services provided to Medicaid beneficiaries. A CPE

[18]For purposes of this report, we use the terms provider taxes and health care provider taxes interchangeably. Provider taxes are defined as a licensing fee, assessment, or some other mandatory payment that is related to a health care service, the provision of or authority to provide the service, or the payment for the service. These taxes qualify as health care related if at least 85 percent of the burden falls on health care providers.

[19]Under federal regulations, there are 18 defined categories of services on which provider taxes may be imposed, which include inpatient and outpatient hospital services, nursing facility services, physician services, and services provided through managed care organizations.

represents the total costs (both the federal and the nonfederal share) incurred for the Medicaid services. The state has the flexibility to send the federal matching funds it receives to the local government or local government provider that certified the expenditure or may retain some or all of those funds.

State funds that may be used to meet the requirement that at least 40 percent of the nonfederal share of Medicaid be derived from state funds include state general funds, health care provider taxes imposed by the state, provider donations received by the state, and intra-agency funds from non-Medicaid state agencies. The remaining 60 percent of the nonfederal share for total annual Medicaid expenditures can be derived from local governments. For example, local governments (such as counties and cities) may contribute up to 60 percent of the nonfederal share through IGTs and CPEs.[20] The limit on the percentage of the nonfederal share that may be financed by local governments is applied on the basis of each state's total annual Medicaid expenditures and not on individual payments or types of payments.

Although use of provider taxes and local-government-provided IGTs and CPEs to finance Medicaid, including increasing provider payments is allowed under federal law, their use has raised concerns about states' ability to shift costs to the federal government. In the late 1980s, some states began to establish financing arrangements that maximized federal Medicaid matching funds, for example, by making new payments to the same providers that were subject to taxes that states used to finance the nonfederal share of those payments.[21] In response to these financing arrangements, Congress established federal requirements in the early 1990s to limit states' ability to rely on provider taxes and donations. After federal requirements were established to limit provider taxes and donations, some states implemented similar arrangements involving IGTs from local government providers and DSH and UPL payments to the

[20]Local governments may also impose health care provider taxes or receive provider donations that may be used for the nonfederal share if they are in compliance with federal requirements. Revenue from these sources is generally transferred from the local government to the state through an IGT.

[21]Starting in the mid-1980s and early 1990s, states also began to rely on providers to make large donations as part of financing arrangements to maximize federal matching funds. States would then return the donations by making large Medicaid payments to the providers that donated the funds, and the states would claim federal matching funds on those payments.

same providers. We found that the outcome was the same in that states maximized federal matching funds by making large payments—significantly above providers' costs of providing services—to providers that were financing the nonfederal share.[22] Congress and CMS also took certain actions to curtail some of the practices involving excessive DSH and UPL payments. However, Congress did not impose requirements upon states' use of IGTs and CPEs from local governments to finance the nonfederal share in the same manner as it did for provider taxes and donations. (See app. II for more details on the history of these Medicaid financing arrangements used to generate federal payments and the federal response to restrict them.)

Certain limits and reporting requirements exist for provider taxes and donations and other sources of funds. For example, when levying a provider tax, states must not hold providers harmless (e.g., must not provide a direct or indirect guarantee that providers will receive their money back). Table 1 provides a summary of federal statutory and regulatory requirements for health care provider taxes, provider donations, IGTs, and CPEs.

[22]See GAO, *Medicaid Financing: Long-standing Concerns about Inappropriate State Arrangements Support Need for Improved Federal Oversight*, GAO-08-650T (Washington, D.C.: Apr. 3, 2008).

Table 1: Federal Statutory and Regulatory Requirements Governing Use and Reporting for Health Care Provider Taxes, Provider Donations, Intergovernmental Transfers, and Certified Public Expenditures

Source of funds	Federal requirements governing use	Federal reporting requirements
Health care provider taxes[a]	• Tax (1) must be broad-based (i.e., imposed on all nonfederal, nonpublic providers within a category of services in the state); (2) must be uniformly imposed (e.g., the tax is the same amount for all providers furnishing the services within the same category);[b] and (3) must not hold providers harmless (e.g., must not provide a direct or indirect guarantee that providers will receive all or a portion of tax payments back) • Taxes that are at or below 6 percent of the individual provider's net patient service revenues are considered not to have provided an indirect guarantee that providers will receive their tax payments back[c]	• States must submit a request if seeking a waiver of the broad-based and uniform requirement • States must report their revenues from provider taxes on a quarterly basis
Provider donations[d]	• Donations must be bona fide. To be bona fide, the donor must not be held harmless.[e] • If the donations do not exceed $5,000 for individual provider or $50,000 for health care organization per year, they are deemed to be bona fide. However, donations may not have a hold-harmless provision that would return the funds, in all or part, to the donor.	• States must report their revenues from provider donations on a quarterly basis
Intergovernmental transfer (IGT)[f]	• Federal law does not restrict states' use of funds when funds are transferred from local governments.[g]	• None
Medicaid certified public expenditure	• Federal law does not restrict states' use of funds when funds are certified as matchable expenditures by local governments.	• None

Source: GAO analysis of federal laws and regulations. | GAO-14-627

Note: Centers for Medicare & Medicaid Services (CMS) officials stated that they also request that states provide additional information on the sources of the nonfederal share in certain circumstances. For example under a 2013 policy, states must annually report on provider payments to demonstrate compliance with the UPL. As part of this reporting, CMS asks states to identify the sources of the nonfederal share for these payments which may include provider taxes, provider donations, IGTs and CPEs.

[a]42 U.S.C. § 1396b(w), 42 C.F.R. § 433.55-.74. If a tax is imposed by a local government, the tax must extend to all services or providers within a category in the area over which the local government has jurisdiction.

[b]States may seek CMS approval of a waiver of either the broad-based or uniformly imposed requirements. CMS may waive these requirements only if the net impact of the tax is generally redistributive and not directly correlated with Medicaid payments to the providers subject to the tax.

[c]Taxes at or below the 6 percent threshold are automatically determined to comply with the indirect guarantee test, which is one of the three tests required for the hold-harmless requirement. Specifically, the indirect guarantee test ensures that states do not provide a direct or indirect guarantee that providers will receive their tax payments back. However, states still must comply with the remaining hold-harmless provisions. The positive correlation test is violated if a provider paying the tax received a payment that is positively correlated to the tax amount or the difference between the provider's Medicaid payment and the tax amount. The Medicaid payment test is violated if all or any portion of the Medicaid payment to the provider varies based only on the amount of the total tax payment.

[d]42 U.S.C. § 1396b(w), 42 C.F.R. § 433.54-.74.

[e]CMS recently issued guidance explaining an application of this requirement. In May 2014, CMS issued a State Medicaid Director Letter that identified arrangements that CMS would find unallowable because under the arrangement, the provider is held harmless for its donation (e.g., provided a direct or indirect guarantee that the provider will receive all or a portion of the donation back).

[7]42 U.S.C. § 1396b(w)(6).

[8]States are prohibited from using IGTs as the nonfederal share if the funds transferred by the local government were derived from provider taxes or provider-related donations that did not meet federal requirements. 42 U.S.C. § 1396b(w)(6).

In recent years a number of proposals have been made to further curtail states' ability to tax providers for purposes of financing the nonfederal share of Medicaid payments. These proposals have sought to lower the tax rate threshold over which the tax is considered to provide a direct or indirect guarantee that providers will receive their tax payments back. The threshold is currently 6 percent of net patient service revenues.[23] The proposals estimated federal savings in the tens of billions of dollars. The basis for the savings is that as a result of reducing the threshold, states would have less tax revenue to finance the nonfederal share, and if states were unable to replace this reduction with funds from other sources of the nonfederal share, then states would reduce Medicaid payments. For example:

- The President's 2013 budget included a proposal for a phased reduction of the health care provider tax threshold from 6 percent of net patient revenues in 2014 to 3.5 percent in 2017 and beyond.[24] It was estimated that the proposal would result in federal Medicaid savings of $21.8 billion from 2015 through 2022.
- In 2010 the National Commission on Fiscal Responsibility and Reform issued a series of deficit reduction proposals, including a proposal to curtail and eventually eliminate health care provider taxes. The commission estimated that the proposal would result in federal Medicaid savings of $5 billion in 2015 and $44 billion from 2012 through 2020.[25]

[23]The Tax Relief and Health Care Act of 2006 lowered the threshold from 6 percent to 5.5 percent, from January 1, 2008, to September 30, 2011. The Congressional Budget Office estimated that this reduction in the threshold would reduce federal Medicaid spending by $260 million over this period. The threshold returned to 6 percent on October 1, 2011. Pub. L. No. 109-432, § 403, 120 Stat. 2922, 2994-5 (2006).

[24]See Office of Management and Budget, *Fiscal Year 2013 Budget of the U.S. Government* (Washington, D.C.: 2012).

[25]See National Commission on Fiscal Responsibility and Reform, *The Moment of Truth* (Washington, D.C.: 2010).

- In 2008 the Congressional Budget Office issued a report on various budget-saving proposals that included a proposal for a phased reduction of the health care provider tax threshold from 6 percent to 3 percent, from 2010 through 2014. The Congressional Budget Office estimated that this proposal would result in federal Medicaid savings of $17 billion from 2010 through 2014 and $48 billion over the 9-year period from 2010 through 2019.[26]

[26]See Congressional Budget Office, *Budget Options Volume I: Health Care* (Washington, D.C.: 2008).

States Relied on Funds from Health Care Providers and Local Governments to Finance 26 Percent of the Nonfederal Share in 2012, with Percentages Varying Significantly among States

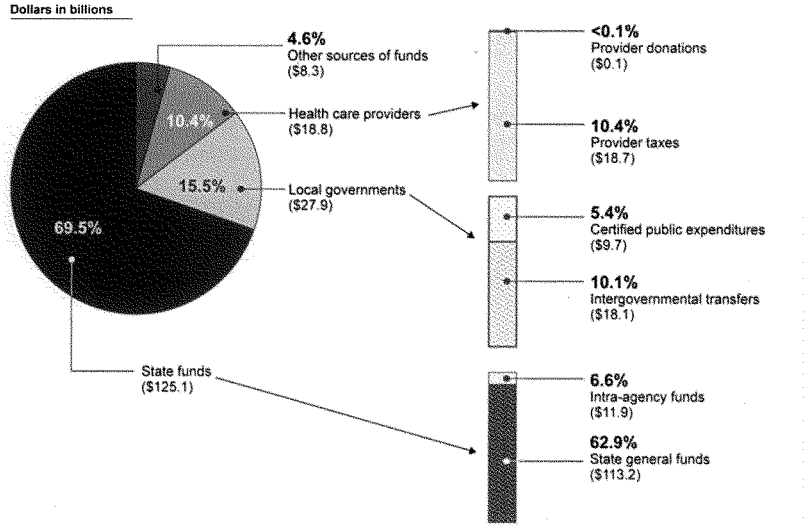
States Collectively Financed 26 Percent, or Over $46 Billion, of the Nonfederal Share with Funds from Providers and Local Governments in 2012

According to our analysis of data reported by states in our questionnaire, states financed 26 percent, or over $46 billion, of the about $180 billion in the total nonfederal share of Medicaid payments with funds from health care providers and local governments in state fiscal year 2012. Health care provider taxes were the largest single source of funds, followed by transfers of funds from local governments. Of the over $46 billion, states received $18.8 billion from health care providers (which includes $72 million from provider donations) and $27.9 billion from local governments ($18.1 billion from IGTs and $9.7 billion from CPEs).[27] The source of funds for most of the remaining $133.1 billion in the nonfederal share was state funds ($113.2 billion, or 62.9 percent, from state general funds and $11.9 billion, or 6.6 percent, from intra-agency funds),[28] while other sources of funds, for example, tobacco settlement funds and state trust funds, totaled $8.3 billion, or 4.6 percent. (See fig. 1.)

[27]The sum of the IGTs and CPEs does not equal the total for local governments because of rounding.

[28]These intra-agency funds include contributions from other state agencies, such as state departments of mental health, that pay Medicaid providers, for example, through an intra-agency agreement; a transfer of funds to the state Medicaid agency from a state government entity that has been appropriated state general funds; or a certification of expenditures for Medicaid-covered services provided to a Medicaid beneficiary from a state government entity that has been appropriated state general funds.

Figure 1: The Percentage and Amount of the Nonfederal Share of Medicaid Payments from Health Care Providers, Local Governments, State Funds, and Other Sources of Funds in State Fiscal Year 2012



Source: GAO. | GAO-14-627

Notes: Provider donations totaled $72 million in 2012. The sum of the intergovernmental transfers and certified public expenditures does not equal the total for local governments because of rounding.

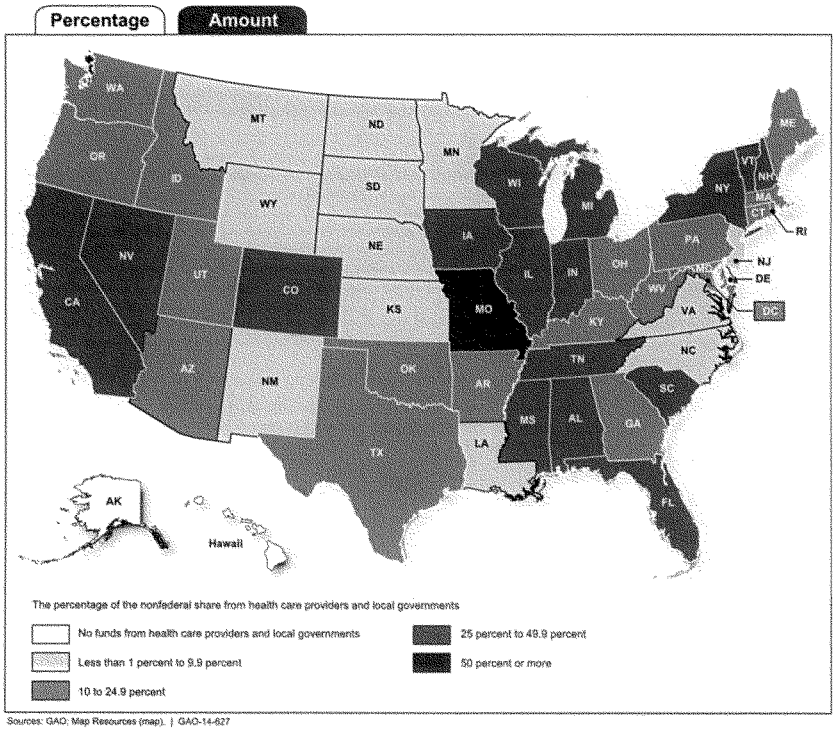
The Nonfederal Share Financed with Funds from Providers and Local Governments Varied Significantly among States in 2012

The percentage and amount of funds from health care providers and local governments that states used to finance the nonfederal share of Medicaid payments varied significantly among states in state fiscal year 2012, based on our analysis of state questionnaire responses. In the 48 states that reported using funds from health providers and local governments, the percentage of funds from providers and local governments ranged from less than 1 percent in South Dakota and Virginia to 53 percent in Missouri. The amount of funds from health care providers and local governments also varied significantly in the 48 states, from $1 million in

South Dakota to over $10 billion in California and New York. (See fig. 2 and app. III.)

Figure 2: The Percentage and Amount of the Nonfederal Share of Medicaid Payments from Health Care Providers and Local Governments in State Fiscal Year 2012, by State

Interactivity instructions: Roll over on one of the two tabs to see data for each category. See appendix III for the non-interactive, printer-friendly version.



Sources: GAO; Map Resources (map). | GAO-14-627

Note: The three states that did not report using funds from health care providers and local governments to finance the nonfederal share in 2012 were Alaska, Delaware, and Hawaii.

States' Reliance on Funds from Providers and Local Governments Has Increased, and Financing Arrangements in Three Selected States Illustrate Cost Shifts to the Federal Government

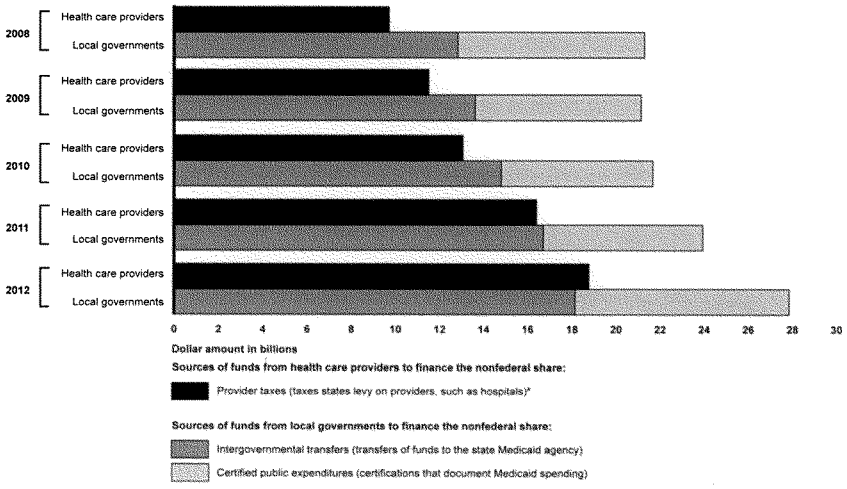
The Percentage of the Nonfederal Share Financed with Funds from Providers and Local Governments Increased by Over 21 Percent from 2008 through 2012

Nationally, states' reliance on funds from health care providers and local governments to finance the nonfederal share of Medicaid payments increased by over 21 percent from state fiscal year 2008 through state fiscal year 2012, based on our analysis of state questionnaire responses. In large part this increase was due to increases in revenues from health care provider taxes. While the total amount of funds from all sources, including state funds, increased from 2008 through 2012, funds from providers and local governments increased as a percentage of the nonfederal share, while state funds decreased. The percentage of funds from health care providers and local governments that states used to finance the nonfederal share increased from 21 percent in 2008 to 26 percent in 2012. Overall, this increase of 5 percentage points represents an over 21 percent increase in the percentage of the nonfederal share financed with funds from health care providers and local governments over the 5-year period. During the same period, the amount of funds from health care providers and local governments increased from $31.0 billion to $46.6 billion, for an increase of about $15.6 billion.[29] Health care provider taxes represented the largest share of the $15.6 billion increase, with an increase of $9.0 billion, from $9.7 billion in

[29]The amount of state funds used to finance the nonfederal share increased from $109.0 billion in 2008 to $125.1 billion in 2012, for an increase of $16.1 billion.

2008 to $18.7 billion in 2012.[30] Provider taxes were typically levied on institutional providers, such as inpatient hospitals and nursing facilities. (See app. IV for more information about states' use of provider taxes to finance the nonfederal share.) The amount of funds transferred from local governments through IGTs and CPEs increased by $6.6 billion, from $21.3 billion in 2008 to $27.9 billion in 2012. (See fig. 3.)

Figure 3: Amount of the Nonfederal Share of Medicaid Payments from Health Care Providers and Local Governments, State Fiscal Years 2008 through 2012



Source: GAO. | GAO-14-627

[a]For purposes of this report, we use the term health care provider tax or provider tax to refer to health care provider taxes, fees, or assessments. The amounts of provider taxes reported include provider donations. Provider donations totaled $17 million in 2008, $16 million in 2009, $78 million in 2010, $69 million in 2011, and $72 million in 2012.

[30]In addition to provider taxes, states reported a much smaller but growing amount of funds from provider donations. Provider donations increased by $55 million, from $17 million in 2008 to $72 million in 2012.

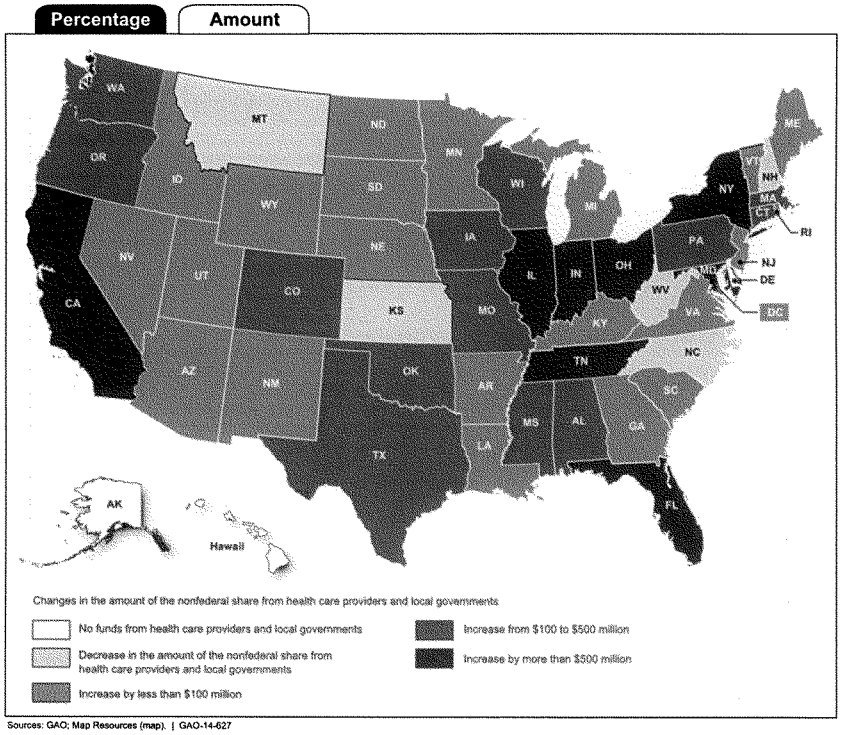
The extent to which states' reliance on health care providers and local governments changed during state fiscal years 2008 through 2012 varied, with most states reporting an increased reliance on health care providers and local governments and a few states reporting a decrease. (See fig. 4 and app. V.) Specifically, 37 states reported an increase in the percentage of the nonfederal share financed with funds from health care providers and local governments, 11 states reported a decrease in the percentage from health care providers and local governments, and 3 states reported no use of funds from health care providers and local governments from 2008 through 2012.[31] Reported increases ranged from about 1 percent in Pennsylvania, which relied on health care providers and local governments for 14.4 percent of the nonfederal share in 2008 and 14.5 percent in 2012, to over 5,000 percent in Idaho, which increased its reliance on health care providers and local governments from less than 1 percent in 2008 to 19 percent in 2012.[32] Of the 11 states that reported a decrease in the percentage of funds from health care providers and local governments used to finance the nonfederal share, 6 states—Kentucky, Minnesota, Missouri, Nevada, North Dakota, and Texas—had a smaller increase in funds from health care providers and local governments relative to increases in the amount of funds from state funds and other sources of funds. The other 5 states—Kansas, Montana, New Hampshire, North Carolina, and West Virginia—reported a decrease in the total amount of funds from health care providers and local governments from 2008 through 2012, for example, because one state ended several of its provider taxes and another discontinued using funds from local governments to finance the nonfederal share of certain Medicaid payments.

[31]The three states are Alaska, Delaware, and Hawaii.

[32]Idaho's increased reliance on health care providers and local governments was due in part to implementing a provider tax on inpatient and outpatient hospitals in 2009 and on nursing facilities in 2010 and discontinuing using state general funds as a source of the nonfederal share of DSH payments beginning in 2010.

Figure 4: Changes in the Percentage and Amount of the Nonfederal Share of Medicaid Payments from Health Care Providers and Local Governments, State Fiscal Years 2008 through 2012, by State

Interactivity instructions: Roll over on one of the two tabs to see data for each category. See appendix V for the non-interactive, printer-friendly version.



Sources: GAO; Map Resources (map). | GAO-14-627

Note: The three states that did not report using funds from health care providers and local governments to finance the nonfederal share in 2012 were Alaska, Delaware, and Hawaii.

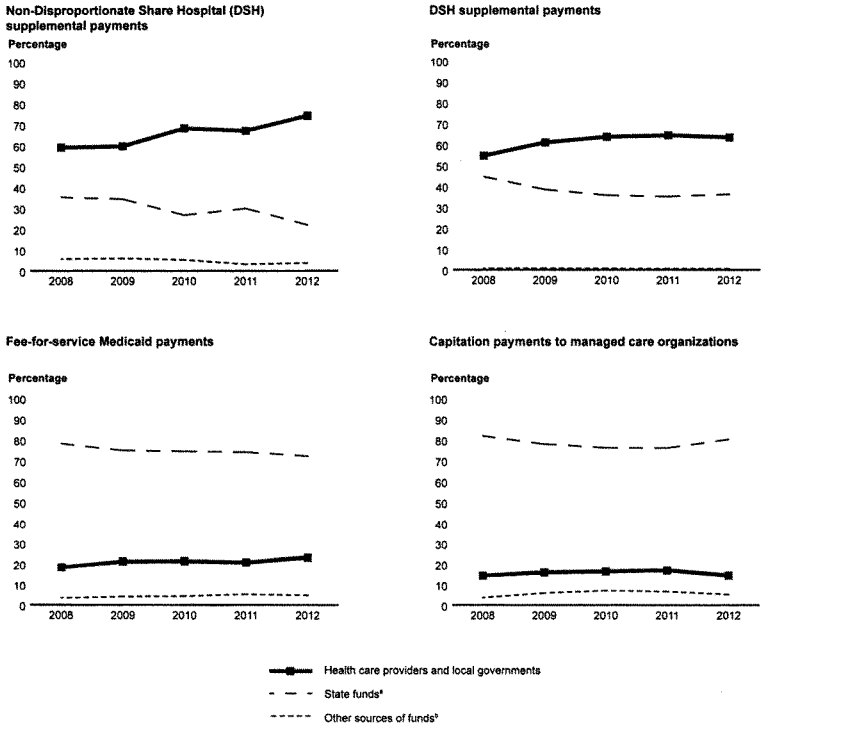
For Supplemental Payments, the Percentage of the Nonfederal Share Financed with Funds from Providers and Local Governments Increased from Over Half to Almost Three-Quarters during 2008 through 2012

Based on our analysis of questionnaire responses, the percentage of the nonfederal share financed with funds from health care providers and local governments for supplemental payments—both DSH and non-DSH—has been relatively high and increasing. In particular, the percentage of the nonfederal share of supplemental payments financed with funds from providers and local governments increased from 57 percent in state fiscal year 2008 to 70 percent in state fiscal year 2012. Overall, this increase of 13 percentage points represents a 24 percent increase in the percentage of the nonfederal share of Medicaid supplemental payments financed with funds from providers and local governments over the 5-year period.

In addition, the percentage of the nonfederal share of supplemental payments financed with funds from providers and local governments was significantly higher than for regular Medicaid payments in each year from state fiscal year 2008 through state fiscal year 2012. For example, as illustrated in figure 5, providers and local governments supplied 59 percent (or $4.2 billion) of the nonfederal share of non-DSH supplemental payments in 2008 and 74 percent (or $9.2 billion) of the nonfederal share of these payments in 2012.[33] Providers and local governments supplied 18 percent (or $18.8 billion) of the nonfederal share of fee-for-service Medicaid payments in 2008 and 23 percent (or $25.8 billion) of the nonfederal share of fee-for-service Medicaid payments in 2012.

[33]Federal law requires that no more than 60 percent of the nonfederal share is financed by local governments. However, this requirement is applied on the basis of total annual Medicaid program spending and not on individual payments or types of payments.

Figure 5: Percentage of Nonfederal Share of Medicaid Payments from Health Care Providers and Local Governments, State Funds, and Other Sources of Funds, State Fiscal Years 2008 through 2012, by Medicaid Payment Type



Source: GAO. | GAO-14-627

[a]"State funds" includes state general funds and intra-agency funds.

[b]"Other sources of funds" includes tobacco settlement funds and state trust funds.

The percentage of the nonfederal share of Medicaid supplemental payments financed with funds from health care providers and local governments varied significantly in state fiscal year 2012 among states that reported using funds from these sources to finance supplemental payments. Several states relied on health care providers and local governments for the entire nonfederal share of their supplemental payments.[34]

- For DSH payments, the percentage of these funds ranged from less than 1 percent in South Dakota to 100 percent in seven states—Colorado, Florida, Idaho, Mississippi, Nevada, South Carolina, and Tennessee.[35] The amount of funds supplied by health care providers and local governments in these seven states totaled $507 million.
- For non-DSH supplemental payments, the percentage of these funds ranged from 10.3 percent in Louisiana to 100 percent in seven states—Alabama, Idaho, Illinois, Nebraska, Nevada, North Carolina, and Wyoming.[36] The amount of funds supplied by health care providers and local governments in these seven states totaled $1.9 billion.

We and others have raised concerns in the past about financing arrangements involving Medicaid supplemental payments, which states often make through large, lump-sum payments to a relatively small

[34]Federal law requires that no more than 60 percent of the nonfederal share is financed by local governments. However, this requirement is applied on the basis of total annual Medicaid program spending and not on individual payments or types of payments.

[35]Thirty-five states reported making DSH payments and using funds from health care providers and local governments to finance these payments; 15 states reported making DSH payments, but did not report using funds from health care providers and local governments to finance these payments; and 1 state did not report making DSH payments in 2012.

[36]Thirty-seven states reported making non-DSH payments and using funds from health care providers and local governments to finance these payments; 10 states reported making non-DSH payments, but did not report using funds from health care providers and local governments to finance these payments; and 4 states did not report making non-DSH payments in 2012.

number of providers.[37] Non-DSH supplemental payments are not typically reported by states on a provider-specific basis. As a result, it makes it difficult to closely assess and oversee states' payments made to individual providers, including those providers that may be supplying funds through IGTs or other sources that states use to finance the nonfederal share of the payments.

Recent Changes in How the Nonfederal Share Was Financed in the Three Selected States Illustrate How Costs Can Shift to the Federal Government

Our analysis of one large financing arrangement involving financing of the nonfederal share of Medicaid payments with funds from provider taxes or IGTs in each of three selected states (California, Illinois, and New York) illustrates how Medicaid costs can be shifted from the state to the federal government, and to a lesser extent, to health care providers and local governments. For example, by increasing providers' Medicaid payments, and requiring providers receiving the payments to supply all or most of the nonfederal share, states claimed an increase in federal matching funds without a commensurate increase in state general funds.

California

During state fiscal year 2011, changes California made to Medicaid payment amounts to nursing facilities and to the financing of these payments had the effect of shifting costs to the federal government and providers.[38] In 2011, California increased regular Medicaid payments for services provided by skilled nursing facilities and increased the existing provider tax rate levied on skilled nursing facilities that became effective in August 2010. As part of the change to the provider tax, CMS approved the state's request for a waiver of the requirements that the tax be broad-based and uniformly imposed. The state requested this waiver because it sought to exempt certain types of nursing facilities from paying the provider tax, such as long-term care facilities that provide a broad range of services, including both skilled nursing services and nonnursing

[37]See GAO-13-48 and Department of Health and Human Services, Office of the Inspector General, Audit of Oregon's Medicaid Upper Payment Limits for Non-State Government Nursing Facilities for State Fiscal Years 2002 and 2003, A-09-03-00055 (Washington, D.C.: 2005); Adequacy of Tennessee's Medicaid Payments to Nashville Metropolitan Bordeaux Hospital, Long-Term-Care Unit, A-04-03-03023 (Washington, D.C.: 2005); and Adequacy of Washington State's Medicaid Payments to Newport Community Hospital, Long-Term-Care Unit, A-10-04-00001 (Washington, D.C.: 2005).

[38]State fiscal year 2011 was from July 1, 2010, through June 30, 2011.

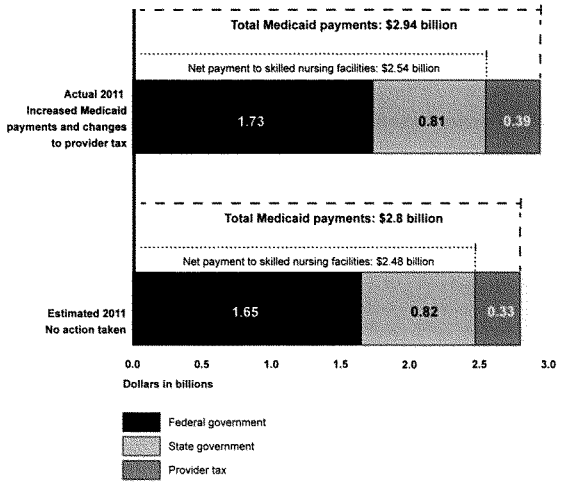
services, and to levy a different tax rate based on the size of the facility as measured by the number of patient days.[39]

By increasing both the regular skilled nursing facility Medicaid payments and the taxes facilities paid, skilled nursing facility Medicaid payments totaled $2.94 billion, federal matching payments totaled $1.73 billion, and the nonfederal share totaled $1.20 billion ($811 million in state general funds and $393 million in provider tax funds). According to our estimates based on 2010 and 2011 Medicaid payment data, had the increased payment and tax changes not gone into effect, skilled nursing facility Medicaid payments would have totaled $2.80 billion, federal matching payments would have totaled $1.65 billion, and the nonfederal share would have totaled $1.15 billion ($822 million in state general funds and $327 million from the unchanged provider tax). (See fig. 6.) The increased regular Medicaid payment and provider tax changes had the effect of increasing federal matching payments by $80 million. The overall increase in net provider payments—that is, the increase in total Medicaid payments ($136 million) minus the increase in provider taxes ($66 million)—was $69 million.[40] The state supplied $11 million less in state general funds than it would have paid had the increased payment and provider tax changes not gone into effect.

[39]The state changed the methodology for calculating the existing provider tax and established two provider tax rates. The state also levied the tax on nursing facilities that were previously exempted from the tax, specifically, certain multilevel facilities. However, some facilities were still exempted from the tax.

[40]The difference between the increase in total Medicaid payments and the increase in provider taxes does not equal $69 million because of rounding.

Figure 6: Estimated Effect of Increased Medicaid Payments and Changes to Provider Tax on Federal and Nonfederal Share of Total Regular Medicaid Payments and on Net Medicaid Payments to Skilled Nursing Facilities in California in State Fiscal Year 2011



Source: GAO. | GAO-14-627

Notes: Under the American Recovery and Reinvestment Act of 2009, states received an increased federal medical assistance percentage (FMAP) from October 1, 2008, through December 31, 2010, extended by subsequent legislation through June 30, 2011. Generally, from October 1, 2008, through December 31, 2010, the increase across the states was at least 6.2 percentage points plus additional federal funds targeted to states with significant increases in unemployment, with a lower increase available from January through June 2011. For purposes of this report, we have estimated that California's FMAP in state fiscal year 2011 was 59.0 percent. The sum of the federal government, state government, and provider tax dollars may not equal total Medicaid payments because of rounding. Net payment to skilled nursing facilities does not equal total Medicaid payments minus provider taxes because of rounding.

Illinois

In state fiscal year 2012, changes Illinois made to Medicaid payment amounts to nursing facilities and the financing of these payments had the effect of shifting costs to the federal government and providers.[41] In state fiscal year 2012, both an increase in regular Medicaid payments for nursing facilities and a new provider tax levied on nursing facilities were in effect.[42] These two actions lessened the effect the loss of the enhanced FMAP would have had on the state in 2012. Under the American Recovery and Reinvestment Act of 2009 (Recovery Act), Illinois's enhanced FMAP was phased out in 2012.[43] The state did not request a waiver of the requirements that the tax be broad-based and uniformly imposed, and CMS found that the tax was permissible and approved the state plan amendment for the payment change.

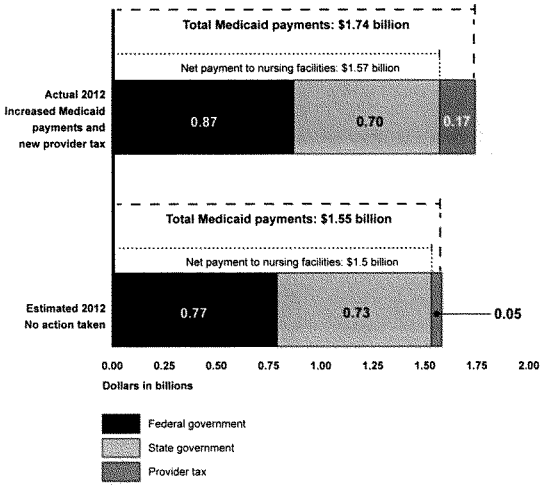
By increasing regular nursing facility Medicaid payments and implementing an additional provider tax on nursing facilities in 2012, total nursing facility Medicaid payments increased to $1.74 billion, federal matching payments totaled $871 million, and the nonfederal share totaled $869 million ($706 million in state general funds and $163 million in provider tax funds). According to our estimates based on 2011 and 2012 Medicaid payment data, had the increased payment and tax not gone into effect, nursing facility Medicaid payments would have totaled $1.52 billion, federal matching payments would have totaled $761 million, and the nonfederal share would have totaled $760 million ($712 million in state general funds and $48 million from an existing provider tax). (See fig. 7.) The increased regular Medicaid payment and new provider tax had the effect of increasing federal matching payments by $110 million. The overall increase in net provider payments—that is, the increase in total Medicaid payments ($220 million) minus the total cost of provider tax ($115 million)—was $105 million. The state supplied $5 million less in state general funds than it would have paid had the increased payment and new provider tax not gone into effect.

[41]State fiscal year 2012 was from July 1, 2011, through June 30, 2012.

[42]The increase in regular Medicaid payments for nursing facilities took effect on May 1, 2011, and the new provider tax levied on nursing facilities took effect on July 1, 2011.

[43]Under the Recovery Act, states received an increased FMAP from October 1, 2008, through December 31, 2010, extended by subsequent legislation through June 30, 2011. Generally, from October 1, 2008, through December 31, 2010, the increase across the states was at least 6.2 percentage points plus additional federal funds targeted to states with significant increases in unemployment, with a lower increase available from January through June 2011.

Figure 7: Estimated Effect of Increased Medicaid Payments and New Provider Tax on Federal and Nonfederal Share of Total Regular Medicaid Payments and on Net Medicaid Payments to Nursing Facilities in Illinois in State Fiscal Year 2012



Source: GAO. | GAO-14-627

Notes: Under the American Recovery and Reinvestment Act of 2009, states received an increased federal medical assistance percentage (FMAP) from October 1, 2008, through December 31, 2010, extended by subsequent legislation through June 30, 2011. Generally, from October 1, 2008, through December 31, 2010, the increase across the states was at least 6.2 percentage points plus additional federal funds targeted to states with significant increases in unemployment, with a lower increase available from January through June 2011. For purposes of this report, we have estimated that Illinois's FMAP in state fiscal year 2012 was 50.1 percent. In state fiscal year 2012, the FMAPs in effect in Illinois were 50.2 percent from July 1, 2011, through September 30, 2011, and 50.0 percent from October 1, 2011, through June 30, 2012.

New York

In state fiscal year 2009, changes New York made to Medicaid payments for inpatient hospital services and increases in the amount of IGTs from a local government had the effect of shifting costs for new Medicaid payments to the federal government and local government.[44] At the same time, the FMAP increased under the Recovery Act. For state fiscal year 2009, New York reduced its regular Medicaid payment rates for inpatient hospital services. In state fiscal year 2009, the state increased the amount of non-DSH supplemental payments it made for inpatient services, which resulted in increased payments to two local government hospitals. The state financed the nonfederal share of these payments with IGTs from the local government that owns and operates the two hospitals. In 2008, state regular payments to the two hospitals totaled $105 million and supplemental payments totaled $218 million. In 2009, state regular payments to the two hospitals totaled $124 million and supplemental payments totaled $356 million to the two hospitals. As illustrated in figure 8, as a result of these actions[45]:

- Total Medicaid payments to the two local government hospitals for inpatient services increased by $157 million, from $322 million in 2008 to $480 million in 2009.[46]
- Provider payments net the amount of IGTs increased by $119 million, from $199 million in 2008 to $318 million in 2009.
- Federal matching funds for regular Medicaid payments and non-DSH supplemental payments increased by $118 million, from $175 million in 2008 to $294 million in 2009.[47] An estimated $33 million of the increase is attributable to an increase in the FMAP under the Recovery Act.

[44]State fiscal year 2009 was from April 1, 2009, through March 31, 2010.

[45]The amount of non-DSH supplemental payments the state can make to local government hospitals is based on the difference between the state's regular Medicaid payments and the upper limit on what the federal government will pay as its share of Medicaid payments, which is based on what Medicare would pay for comparable services. As a result, by lowering regular Medicaid payment rates, the state was able to increase the amount of non-DSH supplemental payments it could make.

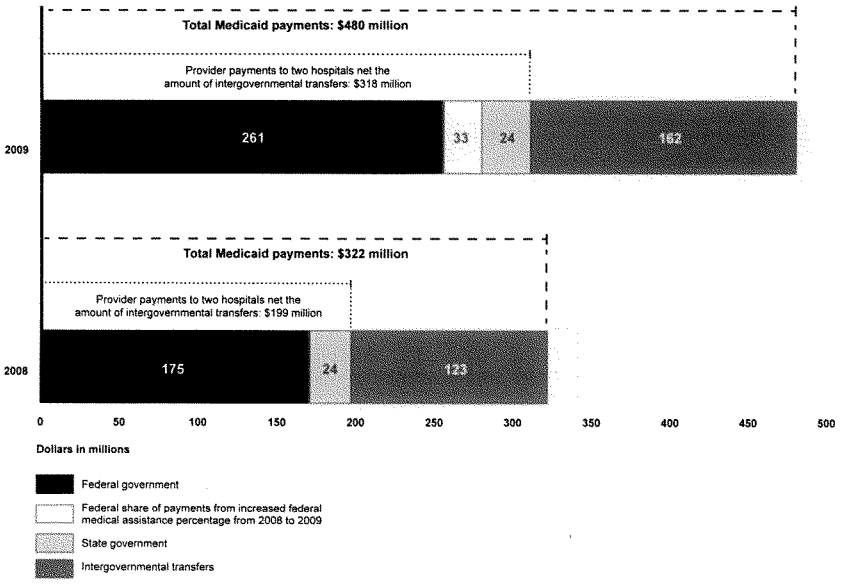
[46]The difference between the total Medicaid payments in 2008 and 2012 does not equal $157 million because of rounding.

[47]The difference between the federal matching funds in 2008 and 2012 does not equal $118 million because of rounding.

- State general funds for regular Medicaid payments did not change, totaling $24 million in both 2008 and 2009.[48]

[48]State general funds were not used to finance the nonfederal share of non-DSH supplemental payments in 2008 or 2009.

Figure 8: The Effect of Increased Medicaid Supplemental Payments and Amounts of Intergovernmental Transfers on Federal and Nonfederal Share of Total Medicaid Payments and on Medicaid Payments Net of Intergovernmental Transfers for Inpatient Services to Two Hospitals in New York from State Fiscal Years 2008 to 2009



Source: GAO. | GAO-14-627

Notes: Under the American Recovery and Reinvestment Act of 2009, states received an increased federal medical assistance percentage (FMAP) from October 1, 2008, through December 31, 2010, extended by subsequent legislation through June 30, 2011. Generally, from October 1, 2008, through December 31, 2010, the increase across the states was at least 6.2 percentage points plus additional federal funds targeted to states with significant increases in unemployment, with a lower increase available from January through June 2011. For purposes of this report, we have estimated that New York's FMAP in state fiscal year 2009 was 61.2 percent.

In total, our analysis of states' questionnaire responses shows that all three states relied on funds from health care providers and local governments to finance billions of dollars of the nonfederal share of

Medicaid. As illustrated in table 2, in California, Illinois, and New York the amount of funds from health care providers and local governments increased from state fiscal year 2008 through state fiscal year 2012. For California and Illinois, the state's reliance on funds from providers and local governments to finance the nonfederal share increased as the percentage of the nonfederal share that states financed with funds from them increased. In New York, while reliance on providers and local governments remained about the same, the state received more than one-third of funds to finance the nonfederal share from health care providers and local governments in 2008 and 2012.

Table 2: The Amount and Percentage of the Nonfederal Share of Medicaid Payments States Financed with Funds from Health Care Providers and Local Governments, State Funds, and Other Sources of Funds in California, Illinois, and New York in State Fiscal Years 2008 and 2012

Dollars in billions

State	Funds from	2008 Dollars (percentage of nonfederal share)	2012 Dollars (percentage of nonfederal share)
California	Health care providers and local governments[a]	$6.3 (33%)	$10.4 (41%)
	State funds[b]	12.5 (67)	14.8 (59)
	Other sources of funds[c]	0.0 (0)	0.0 (0)
	Total nonfederal share	**18.8 (100)**	**25.2 (100)**
Illinois	Health care providers and local governments	0.8 (13)	1.9 (31)
	State funds	4.8 (76)	3.9 (63)
	Other sources of funds	0.7 (11)	0.4 (6)
	Total nonfederal share	**6.3 (100)**	**6.2 (100)**
New York	Health care providers and local governments	8.1 (35)	10.3 (36)
	State funds	15.3 (65)	18.4 (64)
	Other sources of funds	0.0 (0)	0.0 (0)
	Total nonfederal share	**23.4 (100)**	**28.6 (100)**

Source: GAO. | GAO-14-627

Note: Dollars may not equal totals because of rounding.

[a]"Health care providers and local governments" includes funds from health care providers though provider taxes and provider donations and from local governments through intergovernmental transfers and certified public expenditures.

[b]"State funds" includes state general funds and intra-agency funds.

[c]"Other sources of funds" includes tobacco settlement funds and state trust funds.

CMS Has Not Ensured Its Data on Sources of Funds States Use to Finance Medicaid Are Accurate and Complete, and New Reporting Initiatives Fall Short of What Is Needed for Oversight

CMS Has Not Ensured Its Data to Oversee States' Use of Provider Taxes and Funds from Local Governments Are Accurate and Complete

CMS has not assessed the accuracy and completeness of data it collects from states on the amount of health care provider taxes and provider donations states use to finance the nonfederal share of Medicaid payments. Since 1992, states have been required to report the amount of funds collected from health care provider taxes and provider donations.[49] Under federal regulations, CMS has the authority to withhold federal matching funds for states that do not comply with these reporting requirements. In March 2014, CMS officials said that the agency could not attest to the accuracy of data that states reported on their use of provider taxes and donations, but that states were likely underreporting their use of these sources of funds. CMS officials also said that the agency has not withheld federal matching funds when it identified that a state's reporting of the amount of funds collected from health care provider taxes and provider donations was incomplete because the data are reported for informational purposes only and not to enable the state to claim federal matching funds. Instead, CMS would inform the state that it is obligated to report these data. CMS officials stated that the agency does not have a systematic process for identifying when data are accurate and complete, but that the agency may identify inaccurate or incomplete reporting when conducting other review activities, such as financial management reviews, which may include an assessment of

[49]States are required to submit information on taxes collected and donations received on the quarterly CMS 64 expenditure report.

provider taxes.[50] When we compared the provider tax data reported to CMS in 2012 with state responses to our questionnaire, we found evidence of incomplete reporting. Specifically, 6 of the 47 states[51] that reported in our questionnaire that they had at least one health care provider tax or provider donation in effect that year did not report a tax or donation to CMS in 2012.[52]

CMS also does not collect complete data from all states on the amount of local government funds—IGTs and CPEs—used to finance the nonfederal share of total annual Medicaid expenditures. Although federal requirements limit the percentage of the nonfederal share that states may finance with IGTs and CPEs, states are not required to submit data on the amount of funds from these sources.[53] CMS does regularly ask states to provide general information on funds from these sources when a state proposes a change to Medicaid payments to providers. Specifically, when a state proposes a state plan amendment to change payments to providers, it is required to answer standard CMS questions, including a question asking states to describe the sources of the nonfederal share used to finance the Medicaid payments. The information provided varies by state, but CMS officials reported that states are not required to identify the amount of funds provided by or on behalf of any specific providers and the amount of total Medicaid payments made to the providers.

[50]Financial management reviews typically look at specific Medicaid service expenditures and are useful in identifying where additional policy clarification or oversight may be needed. In 2012, CMS conducted financial management reviews on health care provider taxes in four states. In 2010 and 2011, CMS did not conduct any financial management reviews on health care provider taxes.

[51]Four states—Alaska, Delaware, Hawaii, and New Mexico—reported in our questionnaire that they did not have any health care provider tax, fee, and/or assessment or provider donation in effect during state fiscal year 2012 and therefore would not have reported information about these sources of the nonfederal share to CMS.

[52]Six states—Arizona, the District of Columbia, New Jersey, South Dakota, Utah, and Virginia—did not report to CMS any health care provider taxes and provider donations as the nonfederal share of Medicaid expenditures. However, these states reported to us that they levied provider taxes in state fiscal year 2012.

[53]Unlike for provider taxes, federal law does not require states to report amounts of IGTs and CPEs used to finance the nonfederal share of Medicaid.

According to federal internal control standards, federal agencies should collect accurate and complete data to monitor programs they oversee.[54] CMS's ability to oversee the Medicaid program is limited because the agency does not collect accurate and complete data on the amount of funds supplied by health care providers and local governments to states to finance the nonfederal share of Medicaid. For example, CMS is unable to identify the extent to which increasing federal funds are a result of state Medicaid payments that are financed with funds supplied by health care providers and how such financing arrangements affect beneficiary access to care.

CMS Has Begun Two Initiatives to Require Improved Reporting of the Nonfederal Share of Medicaid Payments, but Gaps in Needed Data Remain

CMS and others have recognized the need for better data from states on the nonfederal share of Medicaid. In March 2013, CMS issued a State Medicaid Director Letter describing the need for better data and more frequent analysis of Medicaid data, including the sources of nonfederal share of Medicaid payments, to monitor program integrity.[55] CMS noted that states have considerable discretion in the manner in which they operate their programs, but should always employ that flexibility in ways that enhance care, promote overall program effectiveness and efficiency, and safeguard dollars expended, whether originating from federal or state sources. Others have also recognized the need for improved payment and financing information. In particular, the Medicaid and CHIP Payment and Access Commission (MACPAC)—the commission created by Congress to study Medicaid payment and access—reported in March 2014 the need for improved data on the sources of funds used by states to finance the nonfederal share. MACPAC noted the need to identify net Medicaid payments—the amount of Medicaid payment that providers receive less the amount that providers supply toward the nonfederal share of Medicaid—to assess whether payments are set at appropriate levels and to assess the effects of the payments on providers and beneficiaries. MACPAC found that there are insufficient data at the federal level to do this, however, because data regarding sources of the

[54]See GAO, *Standards for Internal Control in the Federal Government*, GAO/AIMD-00-21.3.1 (Washington, D.C.: November 1999).

[55]See Centers for Medicare & Medicaid Services, *Re: Federal and State Oversight of Medicaid Expenditures* (SMD#13-003) (Baltimore, Md.: Mar. 18, 2013).

nonfederal share are not reported to the federal government at the provider level in a readily usable format.[56]

CMS has begun implementing two initiatives that may improve the agency's ability to oversee states' financing of Medicaid payments; however, based on our analysis, as the initiatives are currently designed, data gaps will limit their effectiveness in CMS's oversight of the Medicaid program. CMS's first initiative—to improve oversight of certain Medicaid supplemental payments—requires states to report data more frequently, but gaps in reporting remain. The initiative does not ensure that CMS will have data to allow it and others to assess net payments to providers, particularly to institutional providers that in total receive billions of dollars in Medicaid payments annually. The initiative, which began in June 2013, requires states to, among other actions, report annually on the source of funds for the nonfederal share of Medicaid payments made to hospitals, nursing facilities, and other institutional providers. However, in May 2014, CMS officials said that state reporting of funds from providers for these Medicaid payments would not be required on a facility-specific basis. As a result, CMS will not have information to determine net payments to institutional providers, once provider taxes, IGTs, CPEs, and other sources of funds are considered in view of total payments the provider received.

CMS's second initiative—to enhance its Medicaid claims data system—is expected to collect information on the source of funds for the nonfederal share of Medicaid payments in some, but not all, cases, and has faced implementation delays. CMS is currently developing an enhanced Medicaid claims data system—called the Transformed Medicaid Statistical Information System (T-MSIS)—which it has cited as a key tool for providing the federal government and states with better information with which to manage and monitor Medicaid program integrity, including identifying waste, fraud, and abuse.[57] T-MSIS will require states to report to CMS information not currently collected on individual Medicaid payments, including provider-specific supplemental payments, and sources of funds for the nonfederal share of all Medicaid payments by

[56]See Medicaid and CHIP Payment and Access Commission, *Report to the Congress on Medicaid and CHIP* (Washington, D.C.: March 2014).

[57]See Centers for Medicare & Medicaid Services, *Re: Transformed Medicaid Statistical Information System (T-MSIS) Data (SMD#13-004)* (Baltimore, Md.: Aug. 23, 2013).

provider.[58] States will report payment data more frequently than they are now required to, reporting to CMS monthly instead of quarterly. However, we found that the information on sources of funds for the nonfederal share will be limited. Specifically, in cases where a state used more than one source to finance the nonfederal share of a Medicaid payment (such as a combination of state general funds and IGTs), T-MSIS as currently planned limits the state to reporting one source of the nonfederal share, even if multiple sources are used. CMS officials also noted that states are not likely to submit information on sources of funds for the nonfederal share because most of the states have had difficulties collecting this information at a provider-specific level. In addition, CMS officials said that it is unlikely that T-MSIS will provide complete information for oversight for some time. In February 2014, CMS officials reported that CMS would be able to accept T-MSIS state data files beginning in July 2014. However, CMS officials said that complete reporting from all states is not expected in July and they were uncertain when all states would be capable of reporting all of the new information required under T-MSIS. CMS stated, however, that the agency has informed states of their expectation that all states will be transitioned to T-MSIS by January 2015.

Conclusions

Medicaid represents significant and growing expenditures for the federal government and states. States have increasingly turned to sources of funds other than state general funds to finance the nonfederal share of their Medicaid programs. These sources include levying taxes on health care providers and receiving funding transfers from local governments and local government providers to help finance the nonfederal share of Medicaid. These financing arrangements can have the effect of shifting costs of Medicaid from states to the federal government, while benefits to providers, which may be financing a large share of any new payments, and the beneficiaries whom they may serve are less apparent. Although such arrangements can help provide fiscal relief to states and are allowed under Medicaid, their use has implications for the intergovernmental nature of Medicaid and federal and state partnership. Such arrangements may also provide inappropriate incentives to states to increase payments to providers that are financing the nonfederal share above what states would have paid otherwise, effectively providing an incentive to make

[58]Under T-MSIS there will be approximately 1,000 data elements, as opposed to the approximately 400 data elements states report to CMS under the current Medicaid claims data system.

higher payments to those providers that supplied funds to finance the nonfederal share of the payments. To some extent, the use of providers and local governments that serve beneficiaries to fund new payments may obscure how the payments may be affecting beneficiary access, if at all.

To oversee the Medicaid program and assess the need for and make changes to the program, CMS, federal policymakers, and other stakeholders need accurate and complete information on provider payments and sources of funds to finance the nonfederal share. Without such information, it is difficult to track trends in financing the nonfederal share, to oversee compliance with current limits and requirements on financing the nonfederal share, and to examine the extent to which the federal government's increased spending is commensurate with an increase in net payments realized by providers and, in turn, improves beneficiary access to needed health care services. To understand how best to ensure that the growing program is sustainable and the burden of the program on providers that serve beneficiaries is manageable, it is important to understand the extent to which increased reliance on providers and local governments to fund the nonfederal share of Medicaid primarily serves as a method of fiscal relief for states. CMS does not collect accurate and complete data from all states on the various sources of funds to finance the nonfederal share to make such an assessment. Recent initiatives suggest that CMS recognizes that it needs more accurate and more complete data from states on the sources of the nonfederal share, particularly for Medicaid payments to institutional providers that states may rely on to help finance the nonfederal share, to effectively oversee the program. As currently designed, the initiatives will not provide all the data needed to do so.

Recommendation for Executive Action

We recommend that the Administrator of CMS develop a data collection strategy that ensures that states report accurate and complete data on all sources of funds used to finance the nonfederal share of Medicaid payments. There are short- and long-term possibilities for pursuing the data collection strategy, including

- in the short-term, as part of its ongoing initiative to annually collect data on Medicaid payments made to hospitals, nursing facilities, and other institutional providers, CMS could collect accurate and complete facility-specific data on the sources of funds used to finance the nonfederal share of the Medicaid payments.

- in the long-term, as part of its ongoing initiative to develop an enhanced Medicaid claims data system (T-MSIS), CMS could ensure that T-MSIS will be capable of capturing information on all sources of funds used to finance the nonfederal share of Medicaid payments, and, once the system becomes operational, ensure that states report this information for supplemental Medicaid payments and other high-risk Medicaid payments.

Agency Comments and Our Evaluation

We provided a draft of this report to HHS for comment. In its written comments, HHS acknowledged that it does not have adequate data on state financing methods for overseeing compliance with a certain federal requirement related to the nonfederal share—the 60 percent limit on contributions from local governments to finance the nonfederal share—and that it will examine efforts to improve data collection toward this end. HHS also stated that it is working to identify needs for improvement in current payment and financing review processes. HHS's acknowledgment is consistent with our recommendation to develop a data collection strategy that ensures states report accurate and complete data on all sources of funds used to finance the nonfederal share of Medicaid payments. However, HHS did not concur with two options our recommendation suggested for short- and long-term ways of improving agency data collection. In particular, HHS disagreed with suggestions that facility-specific data are needed for oversight and that T-MSIS may be an appropriate means for collecting financing data. HHS believes that its current financing reviews are sufficiently reviewing provider-level data.

We believe the findings of our report illustrate why more complete data collection is needed. States are increasingly relying on providers and local governments to finance Medicaid payments, which, while allowed under federal requirements, can have the effect of shifting costs of Medicaid from states to the federal government and may be contributing to a lack of transparency around net payments to individual providers. For these reasons we continue to believe it is important that CMS and federal policymakers have more complete information about how increasing federal costs are impacting the Medicaid program, including beneficiaries and the providers who serve them. HHS's comments are reprinted in appendix VI. HHS also provided technical comments, which we incorporated as appropriate.

We are sending copies of this report to the Secretary of Health and Human Services, the Administrator of the Centers for Medicare & Medicaid Services, and other interested parties. In addition, the report is available at no charge on the GAO website at http://www.gao.gov.

If you or your staff have any questions about this report, please contact me at (202) 512-7114 or iritanik@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. Major contributors to this report are listed in appendix VII.

Katherine M. Iritani
Director, Health Care

Appendix I: Scope and Methodology of State Questionnaire and Analysis of Changes in Medicaid Financing in Three Selected States

To examine the extent to which states rely on funds from health care providers and local governments to finance the nonfederal share of Medicaid and the extent to which states' reliance on health care providers and local governments has changed over time, we compiled information from all 50 states and the District of Columbia using a web-based questionnaire.[1] To examine the implications of changes in states' reliance on health care providers and local governments to finance the nonfederal share, we analyzed Medicaid financing data for a selected financing arrangement instituted by the state in a nongeneralizable sample of three selected states.

Information on Funds Used to Finance the Nonfederal Share from 50 States and the District of Columbia

To provide information about the extent to which states are relying on funds from health care providers and local governments to finance the nonfederal share of Medicaid and how this reliance has changed in recent years, we analyzed data from our web-based questionnaire sent to knowledgeable Medicaid officials in all 50 states and the District of Columbia. The questionnaire asked about states' use of various sources of funds to finance the nonfederal share of Medicaid expenditures during state fiscal years 2008 through 2012. Specifically, the questionnaire requested data on the following:

- The total amount of each of the following sources of the nonfederal share:
  - state general funds;
  - health care provider taxes, fees, and/ or assessments;
  - provider donations;
  - intergovernmental transfers;
  - certified public expenditures;
  - intra-state agency payments/ transfers/ certified public expenditures; and
  - other funding sources

  that were used to finance each of four types of Medicaid payments—capitation payments to managed care organizations; fee-for-service Medicaid payments; Medicaid Disproportionate

[1]For purposes of this report, "states" refers to the 50 states and the District of Columbia.

Share Hospital (DSH) payments; and other Medicaid payments, including supplemental payments made under the Upper Payment Limit, special funding pool payments made under Medicaid demonstrations, and episodic or bundled payments, in each year; and

- The types of provider taxes levied in each state, the ways in which taxes are levied, and the uses of revenue collected from the taxes.

During the development of our questionnaire, we pretested it with state Medicaid officials from four states—Connecticut, Georgia, Missouri, and New York—to ensure that our questions and response choices were clear, appropriate, and answerable. The states selected for a pretest were diverse with respect to the size of Medicaid program and geography. We made changes to the content of the questionnaire based on their feedback. Questionnaire fielding began on July 1, 2013, and we received the final state response on November 14, 2013. All 51 states responded to the questionnaire.

Because we sent the questionnaire to knowledgeable Medicaid officials in each of the 51 states, it was not subject to sampling error. However, the practical difficulties of fielding any questionnaire may introduce errors, commonly referred to as nonsampling errors. For example, differences in how a particular question was interpreted, in the sources of information that were available to respondents, or in how the data were entered into a database or were analyzed could introduce unwanted variability, or bias, into the questionnaire results. We encountered instances of nonsampling error in analyzing the questionnaire responses. Specifically, in some instances, respondents provided conflicting, unclear, or incomplete information. We generally addressed these errors by contacting the state Medicaid department officials involved and clarifying their responses. We did not independently verify the data reported by states in the questionnaire; however, we reviewed published data submitted by state Medicaid programs to the Centers for Medicare & Medicaid Services (CMS) and to outside researchers to assess the reasonableness of the data reported. We believe the data are reliable for our purposes. Assessing compliance with federal requirements and limits related to nonfederal sources of funds was not within the scope of this review.

Analysis of Changes in Financing of Nonfederal Share in California, Illinois, and New York for Selected Financing Arrangements

To obtain more in-depth information on the potential implications of changes in states' reliance on health care providers and local governments to finance the nonfederal share, we interviewed state Medicaid department officials and officials from hospitals and nursing home provider associations, and analyzed data from a nongeneralizable sample of three states: California, Illinois, and New York. To ensure that we identified a range of states for our in-depth analysis, we selected states with

- large Medicaid programs, based on spending for Medicaid services in 2010;
- large amounts of spending for certain supplemental Medicaid payments to providers;
- reported use of various sources of funds to finance the nonfederal share;
- reported changes to regular Medicaid payment rates or amounts in a given year from 2008 through 2011 and a reported new or changed provider tax during the same year;[2] and
- geographic diversity.

These criteria allowed us to obtain information from state Medicaid departments in a diverse mix of states, but the findings from our in-depth analysis cannot be generalized to all states.

We identified and selected one large financing arrangement in each selected state. We asked Medicaid officials from each selected state to identify the largest increase in funds from health care providers and local governments as a result of a new or revised source of funds during state fiscal years 2008 through 2012.[3] Based on states' responses, we then obtained and analyzed Medicaid payment data for one increase in each state. Specifically, we obtained and analyzed Medicaid payment data from before and after the increase to assess the effect of the change on

[2]See GAO, *Medicaid: State Made Multiple Program Changes, and Beneficiaries Generally Reported Access Comparable to Private Insurance*, GAO-13-55 (Washington, D.C.: Nov. 15, 2012).

[3]We asked for the largest change in funds for four types of Medicaid services—inpatient hospital services, outpatient hospital services, nursing facility services, and intermediate care facility services for the intellectually disabled.

the amounts of Medicaid payments providers received and on the amounts of state general funds and federal funds used for these payments. As part of our analysis in California and Illinois, we estimated the amount of regular Medicaid payments to providers, provider taxes collected, and the state and federal share of Medicaid had the increases in provider taxes and Medicaid payments not taken place. We did not independently verify the accuracy of the reported Medicaid data. However, we checked the data for discrepancies and omissions and interviewed state officials to resolve any identified discrepancies. On the basis of this review, we determined that the Medicaid data were sufficiently reliable for the purposes of this report.

To gather additional information related to both the extent to which states are relying on funds from health care providers and local governments to finance the nonfederal share of Medicaid and the extent to which states' reliance on funds from health care providers and local governments to finance the nonfederal share of Medicaid payments has changed over time, and the implications of any changes, we interviewed a range of experts and organizations. For example, we interviewed CMS officials, including representatives from regional offices; experts from the National Association of Medicaid Directors, the National Conference of State Legislatures, the National Association of State Budget Officers, the National Association of Counties, and the Medicaid and CHIP Payment and Access Commission; as well as officials from the American Hospital Association and American Health Care Association in each state of our nongeneralizable sample of states.

Appendix II: Medicaid Financing Arrangements Used to Generate Federal Payments and Actions to Address Them

Financing arrangement	Description	Federal legislative and regulatory action taken from 1987 through 2002
Excessive payments to state health facilities	States made excessive Medicaid payments to state-owned health facilities, which subsequently returned these funds to the state treasuries.	In 1987, the Health Care Financing Administration (HCFA, now called the Centers for Medicare & Medicaid Services, or CMS) issued regulations that established payment limits specifically for inpatient and institutional facilities operated by states.
Provider taxes and donations	Revenues from provider-specific taxes on hospitals and other providers and from provider "donations" were matched with federal funds and paid to the providers. These providers could then return most of the federal payment to the states.	The Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 imposed restrictions on provider donations and provider taxes.
Excessive Disproportionate Share Hospital (DSH) payments	DSH payments are meant to compensate those hospitals that care for a disproportionate number of low-income patients. Unusually large DSH payments were made to certain hospitals, which then returned the bulk of the state and federal funds to the state.	The Omnibus Budget Reconciliation Act of 1993 placed limits on which hospitals could receive DSH payments and capped the amount of DSH payments individual hospitals could receive.
Excessive DSH payments to state mental hospitals	A large share of DSH payments were paid to state-operated psychiatric hospitals, where they were used to pay for services not covered by Medicaid or were returned to the state treasuries.	The Balanced Budget Act of 1997 limited the proportion of a state's DSH payments that can be paid to institutions for mental disease and other mental health facilities.
Upper Payment Limit (UPL) for local government health facilities	In an effort to ensure that Medicaid payments are reasonable, federal regulations prohibit Medicaid from paying more than a reasonable estimate of the amount that would be paid under Medicare payment principles for comparable services. This UPL applies to payments aggregated across a class of facilities and not for individual facilities. As a result of the aggregate upper limit, states were able to make large supplemental payments to a few local public health facilities, such as hospitals and nursing homes. The local government health facilities then returned the bulk of the state and federal payments to the states.	The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 required HCFA to issue a final regulation that established a separate aggregate payment limit for local government health facilities. HCFA issued its final regulation on January 12, 2001. In 2002, CMS issued a regulation that further lowered the payment limit for local public hospitals.

Source: GAO. | GAO-14-627

Note: See GAO, *Medicaid Financing: Long-standing Concerns about Inappropriate State Arrangements Support Need for Improved Federal Oversight*, GAO-08-650T (Washington, D.C.: Apr. 3, 2008).

Appendix III: Percentage and Amount of the Nonfederal Share of Medicaid from Providers and Local Governments in 2012

Table 3 presents information from interactive figure 2 on the percentage and amount of the nonfederal share from health care providers and local governments in each state in state fiscal year 2012.

Table 3: The Percentage and Amount of the Nonfederal Share of Medicaid Payments from Health Care Providers and Local Governments in State Fiscal Year 2012, by State

State	Percentage	Dollar amount
Alabama	46.3%	$812,910,877
Alaska	0.0	0
Arizona	21.9	548,422,860
Arkansas	19.6	214,212,997
California	41.4	10,438,370,617
Colorado	27.2	622,957,553
Connecticut	16.0	524,890,185
Delaware	0.0	0
District of Columbia	10.6	43,149,746
Florida	33.6	3,481,414,295
Georgia	18.0	561,002,851
Hawaii	0.0	0
Idaho	18.6	83,074,695
Illinois	31.1	1,935,546,522
Indiana	37.3	817,409,302
Iowa	27.1	353,865,764
Kansas	3.2	35,689,873
Kentucky	21.3	345,738,461
Louisiana	8.1	181,976,351
Maine	18.1	152,827,017
Maryland	19.7	717,307,156
Massachusetts	12.6	795,911,726
Michigan	33.4	1,391,000,000
Minnesota	8.8	379,151,928
Mississippi	31.0	351,696,744
Missouri	52.5	2,002,329,551
Montana	7.0	21,632,887
Nebraska	4.8	33,874,996
Nevada	25.7	194,547,278
New Hampshire	30.2	192,902,003

State	Percentage	Dollar amount
New Jersey	6.8	366,999,704
New Mexico	8.2	82,744,417
New York	35.9	10,279,054,243
North Carolina	9.7	452,901,232
North Dakota	1.5	4,719,614
Ohio	24.2	1,421,662,970
Oklahoma	13.3	207,411,553
Oregon	17.3	331,000,000
Pennsylvania	14.5	1,320,115,000
Rhode Island	22.5	199,800,000
South Carolina	31.1	462,578,752
South Dakota	0.5	1,283,367
Tennessee	33.4	928,596,969
Texas	13.0	1,487,906,059
Utah	19.1	105,665,100
Vermont	29.1	160,627,958
Virginia	0.9	32,874,899
Washington	20.8	517,066,896
West Virginia	21.7	161,760,948
Wisconsin	32.1	829,634,790
Wyoming	8.4	22,228,565

Source: GAO. | GAO-14-627

Note: "Health care providers and local governments" includes funds from health care providers though provider taxes and provider donations and from local governments through intergovernmental transfers and certified public expenditures.

Appendix IV: Provider Tax Analysis

This appendix provides the results of our analysis of provider tax data states reported in our questionnaire and views expressed by provider association officials we interviewed. In analyzing states' reported data, we calculated the number of new taxes and the reported uses of tax revenue for new taxes implemented from state fiscal years 2008 through 2012 and reviewed the rates at which taxes were levied and how they compared to a federal threshold. In interviewing provider association officials, we obtained their views regarding states' use of provider taxes to finance the nonfederal share of Medicaid payments.

Number of New Taxes and Reported Uses of Tax Revenue

The number of provider taxes in effect increased by 42, or about 36 percent, from 2008 through 2012, and the reported purposes of the new taxes were primarily to finance payments, rather than expand benefits or services, based on our analysis of state questionnaire responses. The total number of provider taxes increased from 117 in 42 states in 2008 to 159 in 47 states in 2012, for an increase of about 36 percent. A total of 85 new provider taxes were implemented in 32 states during this period.[1] When asked in the questionnaire about the uses of revenue from these taxes, states often cited multiple uses, such as financing fee-for-service Medicaid payments (cited 35 times), non-Disproportionate Share Hospital (DSH) supplemental payments (cited 32 times), and DSH supplemental payments (cited 20 times), as well as avoiding cuts in benefits (cited 24 times) and expanding benefits or services (cited 8 times).[2]

[1]From 2008 through 2012, 43 provider taxes were ended. When combined with the 85 new provider taxes implemented from 2008 through 2012, the net increase is 42 provider taxes.

[2]States could report multiple uses for each new tax.

Rates at Which Taxes Are Levied and How They Compare to Federal Threshold

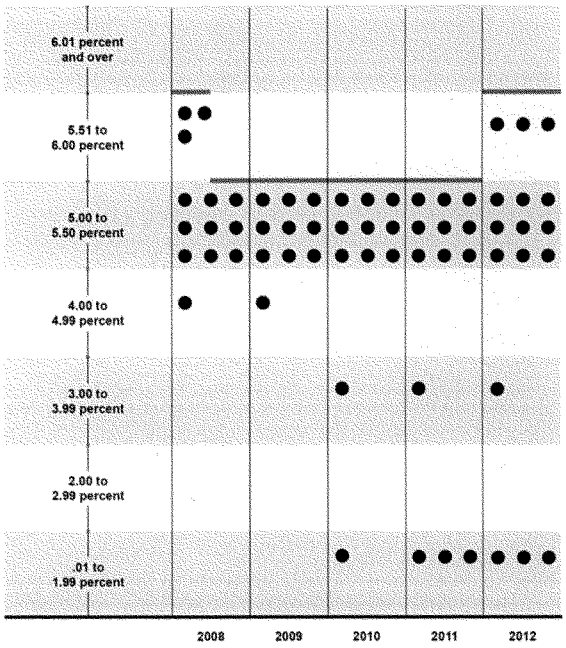
Based on our analysis of state questionnaire responses, of the 775 taxes reported by states, 63 were levied as a percentage of net patient service revenues from 2008 through 2012, and all 63 were at or below the federal hold-harmless threshold and therefore would be deemed not to have provided a guarantee that providers will receive their money back.[3] Under federal requirements, states must not hold providers harmless (e.g., must not provide a direct or indirect guarantee that providers will receive their money back). However, taxes at or below the threshold—6 percent of net patient service revenues in 2012—are deemed to comply with the guarantee requirement. Figure 9 illustrates for each year from 2008 through 2012 the number of tax rates levied as a percentage of net patient service revenue. From 2008 through 2012, most tax rates were within 1 percentage point of the threshold. From 2008 through 2012, the threshold was reduced from 6 to 5.5 percent from January 1, 2008, through September 30, 2011, and then returned to 6 percent beginning in October 1, 2011.[4] During the time the threshold was reduced, states with a tax that was previously at 6 percent reported that their tax rate was reduced to 5.5 percent. According to Centers for Medicare & Medicaid Services (CMS) officials, the agency did not conduct a comprehensive review of states' provider tax rates when the threshold was reduced to ensure that states' tax rates did not exceed the threshold. Moreover, states are not always required to demonstrate to CMS that their taxes are levied at a rate at or below the threshold. CMS may review tax rates on a case-by-case basis when reviewing state plan amendments or conducting other oversight reviews, such as reviews of provider taxes when a state requests a waiver of requirements that the tax be broad-based and uniformly imposed. CMS officials stated that they have an internal system for tracking these waivers. In May 2014, CMS officials stated that from 2008 through 2012, the agency reviewed and approved waivers of the

[3]For purposes of comparing provider taxes to the federal hold-harmless threshold, we identified taxes levied as a percentage of net patient service revenues, and when counting the total number of such taxes, we counted a tax more than once when a tax was levied using different tax rates during a given year. For example, if for 6 months of the year a tax was levied at 4 percent of net patient service revenues, and for the other 6 months the tax was levied at 6 percent of net patient service revenues, we counted this as two taxes. For taxes that were reported as not being levied as a percentage of net patient service revenues, we used a similar approach in counting these taxes.

[4]The Tax Relief and Health Care Act of 2006 lowered the threshold from 6 percent to 5.5 percent, from January 1, 2008, to September 30, 2011. The threshold returned to 6 percent on October 1, 2011. Pub. L. No. 109-432, § 403, 120 Stat. 2922, 2994-5 (2006).

requirements that provider taxes be broad-based and uniformly imposed in 29 states.

Figure 9: Federal Provider Tax Threshold and State Provider Tax Rates for Taxes Levied as a Percentage of Net Patient Service Revenue from 2008 through 2012



Source: GAO. | GAO-14-627

Notes: The federal hold-harmless threshold is based on a federal fiscal year. The Tax Relief and Health Care Act of 2006 lowered the federal hold-harmless threshold from 6 percent to 5.5 percent, from January 1, 2008, to September 30, 2011. The provider tax rates are based on state fiscal years.

The 712 remaining taxes reported by states in our questionnaire were either levied on a percentage of revenues other than net patient service revenues or were not levied as a percentage of revenue. A total of 382 taxes were levied on a percentage of revenues other than net patient services revenues, and included gross revenues, net operating revenues, and non-Medicare patient revenue. In some cases, these taxes were levied at a rate above 6 percent. In May 2014, CMS officials stated that if the agency reviewed a tax levied on a type of revenue other than net patient service revenues, CMS would have the state perform calculations to demonstrate to CMS that if the tax was levied as a percentage of net patient service revenues, it would fall at or below the threshold. A total of 330 taxes were not levied on revenues, and included taxes based on dollar amounts per bed day or a flat tax per year. According to CMS officials, in reviewing these types of taxes, the agency would have the state perform calculations to demonstrate to CMS that if the tax was levied as a percentage of net patient service revenues, it would fall at or below the threshold.

Views of Provider Associations

The officials we interviewed from provider associations representing inpatient hospitals and nursing homes, the most common types of providers taxed, reported that while the providers would prefer not to be subject to a provider tax, the associations have worked with the states to make them acceptable to the providers they represent. Officials from the provider associations said that factors that made provider taxes acceptable to the providers they represent included recognition that

- without the tax revenue, states would likely reduce Medicaid payments to providers;
- revenue from the taxes would be used for making Medicaid payments to providers; and
- the state would provide assurances that tax revenue would be used for Medicaid payments. For example, officials said that one state passed a law requiring the tax revenues to be used to make Medicaid payments, and one state created a fund into which all tax revenues were deposited. Revenues in the fund were used to make Medicaid payments to providers.

Officials noted that providers are more reluctant to accept provider taxes when they lack assurance that the tax revenue would be used for Medicaid payments. Officials also noted that providers that serve fewer Medicaid patients are less accepting of new provider taxes.

Appendix V: Changes in Percentage and Amount of the Nonfederal Share of Medicaid from Providers and Local Governments

Table 4 presents information from interactive figure 4 on changes in the percentage and amount of the nonfederal share from health care providers and local governments in each state during state fiscal years 2008 through 2012.

Table 4: Changes in the Percentage and Amount of the Nonfederal Share of Medicaid Payments from Health Care Providers and Local Governments, State Fiscal Years 2008 through 2012, by State

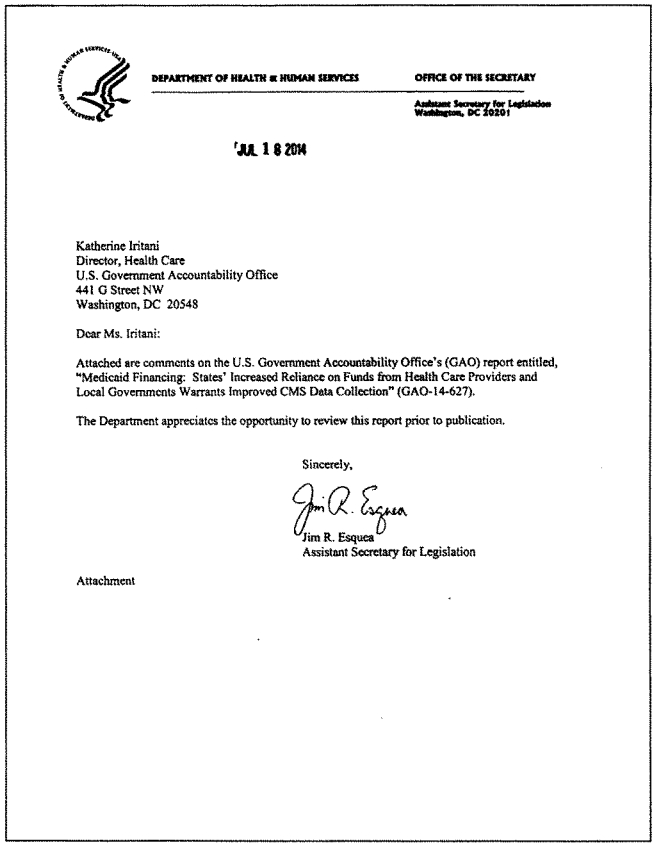
State	Percentage in 2008	Percentage in 2012	Percentage change from 2008 through 2012	Dollar amount in 2008	Dollar amount in 2012	Dollar amount change from 2008 through 2012
Alabama	31.3%	46.3%	48.0%	$473,154,906	$812,910,877	$339,755,971
Alaska	0.0	0.0	0.0	0	0	0
Arizona	18.8	21.9	16.3	455,602,156	548,422,860	92,820,704
Arkansas	13.1	19.6	50.3	118,040,777	214,212,997	96,172,220
California	33.4	41.4	24.1	6,274,278,047	10,438,370,617	4,164,092,570
Colorado	10.1	27.2	169.6	155,313,803	622,957,553	467,643,750
Connecticut	6.4	16.0	151.4	143,430,953	524,890,185	381,459,232
Delaware	0.0	0.0	0.0	0	0	0
District of Columbia	8.9	10.6	19.8	25,392,187	43,149,746	17,757,559
Florida	25.4	33.6	32.5	1,862,821,898	3,481,414,295	1,618,592,397
Georgia	15.6	18.0	15.7	478,021,765	561,002,851	82,981,086
Hawaii	0.0	0.0	0.0	0	0	0
Idaho	0.3	18.6	5361.5	1,174,757	83,074,695	81,899,938
Illinois	12.6	31.1	146.6	793,649,165	1,935,546,522	1,141,897,357
Indiana	6.7	37.3	452.8	120,708,692	817,409,302	696,700,610
Iowa	21.0	27.1	29.0	214,509,247	353,865,764	139,356,517
Kansas	4.3	3.2	(26.4)	38,826,223	35,689,873	(3,136,350)
Kentucky	22.2	21.3	(4.1)	319,339,753	345,738,461	26,398,708
Louisiana	6.9	8.1	17.5	113,087,417	181,976,351	68,888,934
Maine	16.7	18.1	8.8	131,019,354	152,827,017	21,807,663
Maryland	3.9	19.7	411.3	107,533,362	717,307,156	609,773,794
Massachusetts	10.8	12.6	16.1	565,902,437	795,911,726	230,009,289
Michigan	32.1	33.4	4.0	1,314,900,000	1,391,000,000	76,100,000
Minnesota	11.3	8.8	(22.3)	366,101,779	379,151,928	13,050,149
Mississippi	23.2	31.0	33.5	195,350,214	351,696,744	156,346,530
Missouri	55.3	52.5	(5.1)	1,587,922,848	2,002,329,551	414,406,703
Montana	13.5	7.0	(48.3)	30,793,497	21,632,887	(9,160,610)
Nebraska	1.1	4.8	335.1	7,533,963	33,874,996	26,341,033
Nevada	30.5	25.7	(15.8)	183,648,519	194,547,278	10,898,759

State	Percentage in 2008	Percentage in 2012	Percentage change from 2008 through 2012	Dollar amount in 2008	Dollar amount in 2012	Dollar amount change from 2008 through 2012
New Hampshire	43.7	30.2	(30.9)	356,894,685	192,902,003	(163,992,682)
New Jersey	6.6	6.8	3.9	308,083,588	366,999,704	58,916,116
New Mexico	6.8	8.2	21.1	55,636,581	82,744,417	27,107,836
New York	34.7	35.9	3.5	8,101,812,951	10,279,054,243	2,177,241,292
North Carolina	27.8	9.7	(65.2)	1,164,912,666	452,901,232	(712,011,434)
North Dakota	2.0	1.5	(26.8)	3,983,220	4,719,614	736,394
Ohio	16.5	24.2	46.6	813,475,652	1,421,662,970	608,187,318
Oklahoma	6.0	13.3	122.6	65,052,561	207,411,553	142,358,992
Oregon	10.2	17.3	70.4	120,000,000	331,000,000	211,000,000
Pennsylvania	14.4	14.5	0.9	1,117,884,000	1,320,115,000	202,231,000
Rhode Island	16.2	22.5	39.1	139,400,000	199,800,000	60,400,000
South Carolina	25.4	31.1	22.4	368,674,155	462,578,752	93,904,597
South Dakota	0.3	0.5	68.0	683,279	1,283,367	600,088
Tennessee	12.6	33.4	165.8	314,507,257	928,596,969	614,089,712
Texas	13.7	13.0	(5.1)	1,133,953,554	1,487,906,059	353,952,505
Utah	12.2	19.1	56.2	52,094,200	105,665,100	53,570,900
Vermont	21.2	29.1	37.2	93,882,425	160,627,958	66,745,533
Virginia	0.1	0.9	1371.2	1,725,674	32,874,899	31,149,225
Washington	8.2	20.8	153.3	131,320,302	517,066,896	385,746,594
West Virginia	31.0	21.7	(30.1)	183,478,121	161,760,948	(21,717,173)
Wisconsin	17.5	32.1	83.8	380,198,819	829,634,790	449,435,971
Wyoming	3.0	8.4	185.7	6,634,910	22,228,565	15,593,655

Source: GAO. | GAO-14-627

Notes: "Health care providers and local governments" includes funds from health care providers though provider taxes and provider donations and from local governments through intergovernmental transfers and certified public expenditures. Percentages and dollar amounts in parentheses represent a negative number.

Appendix VI: Comments from the Department of Health and Human Services



DEPARTMENT OF HEALTH & HUMAN SERVICES — OFFICE OF THE SECRETARY

Assistant Secretary for Legislation
Washington, DC 20201

JUL 18 2014

Katherine Iritani
Director, Health Care
U.S. Government Accountability Office
441 G Street NW
Washington, DC 20548

Dear Ms. Iritani:

Attached are comments on the U.S. Government Accountability Office's (GAO) report entitled, "Medicaid Financing: States' Increased Reliance on Funds from Health Care Providers and Local Governments Warrants Improved CMS Data Collection" (GAO-14-627).

The Department appreciates the opportunity to review this report prior to publication.

Sincerely,

Jim R. Esquea

Jim R. Esquea
Assistant Secretary for Legislation

Attachment

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED: MEDICAID FINANCING: STATES' INCREASED RELIANCE ON FUNDS FROM HEALTH CARE PROVIDERS AND LOCAL GOVERNMENTS WARRANTS IMPROVED CMS DATA COLLECTION (GAO-14-627)

The Department appreciates the opportunity to review and comment on this draft report.

GAO Recommendation

GAO recommends that the Administrator of the Centers for Medicare & Medicaid Services (CMS) develop a data collection strategy that ensures states report accurate and complete data on all sources of funds used to finance the nonfederal share of Medicaid payments. There are short- and long-term possibilities for pursuing the data collection strategy including--

- In the short-term, as part of its ongoing initiative to annually collect data on Medicaid payments made to hospitals, nursing facilities, and other institutional providers, CMS could collect accurate and complete facility-specific data on the source of funds used to finance the nonfederal share of the Medicaid payments.

CMS Response

HHS non-concurs with GAO's recommendation that additional facility-specific reporting on the source of funds is appropriate at this time. HHS currently collects information necessary to review state compliance with federal regulations and statute related to sources of the non-federal share as part of our regular review procedures. Most of the federal limitations (including contributions from local governments) are aggregate limits; however, to the extent that HHS requires information pertaining to specific providers or units of government to assess state compliance with federal regulations and statute, we believe our current processes are sufficient to gather this information from states. Further, to the extent that state governments (such as counties or other localities) are contributing units of government for the non-federal share, but do not directly receive Medicaid services payments, facility level reporting would not aid HHS in its regulatory oversight responsibilities.

HHS thoroughly reviews the financing associated with each state plan amendment that states submit to propose changes to service payments. With each request, HHS gathers information on the source of the non-federal share, the units of government that intergovernmental transfer (IGT) funds or use certified public expenditures (CPEs), as well as supporting documentation related to health care-related taxes and provider-related donations. The information is analyzed and must be determined as an acceptable basis to serve as a source of the non-federal share before HHS approves a State Plan Amendment (SPA) proposal.

In addition, HHS has recently embarked on new initiatives to improve analytic capacity and provide a more regular process for state financing and upper payment limit data reporting. HHS issued a policy letter on March 18, 2013, that discusses the mutual obligations of states and HHS to apply safeguards to ensure the proper use of federal and state Medicaid funds. As part of the letter, HHS instituted a new policy to require annual submissions that demonstrate compliance with federal upper payment limits (UPL) and information on the source of the non-federal share that is used to fund in some cases facility specific "UPL" supplemental payments. We have engaged with our regional offices to analyze the first state UPL submissions and have engaged with a contractor to aid in the ongoing effort.

As a follow-up to the March letter and in consideration of increased interest by states in financing Medicaid payments through public/private endeavors, we released a second "accountability" State Medicaid Directors Letter on May 9, 2014. This letter clarifies the relationship of public/private endeavors with respect to the provider related donations requirements, so that states have a full understanding of the requirements and examples of arrangements that would be unacceptable.

We do agree that HHS does not have adequate data to verify that states adhere to the 60 percent limitation on contributions from local governments to fund the non-federal share. Currently, we rely on states' assurances within the Medicaid State Plan of compliance with this requirement. As part of our new oversight initiatives, we will examine the feasibility and means for collecting information from states to verify that local government contributions comply with the statutory limit.

GAO Recommendation
GAO recommends that the Administrator of CMS develop a data collection strategy that ensures states report accurate and complete data on all sources of funds used to finance the nonfederal share of Medicaid payments. There are short- and long-term possibilities for pursuing the data collection strategy including--

- In the long-term, as part of its ongoing initiative to develop an enhanced Medicaid claims data system Transformed Medicaid Statistical Information System (T-MSIS), CMS could ensure that T-MSIS will be capable of capturing information on all sources of funds used to finance the nonfederal share of Medicaid payments, and once the system becomes operational, ensure that states report this information for supplemental Medicaid payments and other high-risk Medicaid payments.

Response
HHS non-concurs that T-MSIS, as a claims based system, is the correct method to gather information on the sources of funds that states use to support their Medicaid programs as discussed in the report. T-MSIS will be a valuable tool in other oversight responsibilities, and we will be assessing the potential for using T-MSIS data to assist HHS in analyzing state UPL submissions in the future.

We are also working to identify any data gaps and recommendations for improvement in our current processes for UPL and state share financing reviews, which include provider-level data. The outcome of this work will inform our future policy work and, if necessary, additional data points that may help assess state compliance.

HHS thanks GAO for the work done on this issue and looks forward to working with GAO in the future.

Appendix VII: GAO Contact and Staff Acknowledgments

GAO Contact	Katherine M. Iritani, (202) 512-7114 or iritanik@gao.gov
Staff Acknowledgments	In addition to the contact named above, Tim Bushfield (Assistant Director), Leonard Brown, Carolyn Fitzgerald, Peter Mangano, Vikki Porter, Roseanne Price, and Hemi Tewarson made key contributions to this report.

Related GAO Products

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Medicaid: More Transparency of and Accountability for Supplemental Payments Are Needed. GAO-13-48. Washington, D.C.: November 26, 2012.

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Medicaid: Intergovernmental Transfers Have Facilitated State Financing Schemes. GAO-04-574T. Washington, D.C.: March 18, 2004.

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Medicaid: Disproportionate Share Payments to State Psychiatric Hospitals. GAO/HEHS-98-52. Washington, D.C.: January 23, 1998.

Medicaid: Disproportionate Share Hospital Payments to Institutions for Mental Diseases. GAO/HEHS-97-181R. Washington, D.C.: July 15, 1997.

Medicaid: States Use Illusory Approaches to Shift Program Costs to Federal Government. GAO/HEHS-94-133. Washington, D.C.: August 1, 1994.

July 29, 2014

The Honorable Janice K. Brewer
Governor, State of Arizona
Executive Tower
1700 West Washington Street
Phoenix, AZ 85007

Dear Governor Brewer:

The Committee on Oversight and Government Reform is currently examining the roles of state and federal governments in sharing the costs of the Medicaid program. As part of this review, I am writing to request information about your state's decision to expand Medicaid services under the Affordable Care Act to the residents of your state.

When Congress passed the Affordable Care Act, it offered states the ability to expand Medicaid services for their non-elderly constituents with families below 138% of the Federal poverty level. Congress offered to pay 100% of these costs for the first three years, declining gradually to 90% by 2020, with states paying only 10% of these costs. According to the Center for Medicaid and CHIP Services:

> These critical health coverage programs serve millions of families, children, pregnant women, adults without children and also seniors and people living with disabilities. In addition to covering services like doctor's visits, prescription drugs, and preventive care, Medicaid helps seniors and people with disabilities receive long term services and supports in their communities as well as in nursing homes. Together, these programs provide an important foundation for maintaining the health of our nation.[1]

Democratic governors have consistently supported expanding Medicaid under the Affordable Care Act, but Republican governors have disagreed among themselves, with widely differing explanations. For example:

[1] *Message from the CMCS Director,* Medicaid.gov (online at www.medicaid.gov/About-Us/About-Us.html) (accessed July 27, 2014).

- **Texas Governor Rick Perry:** Explaining his opposition to expanding Medicaid under the Affordable Care Act, Governor Perry stated: "It's like putting 1,000 more people on the Titanic when you knew what was going to happen."[2]

- **Florida Governor Rick Scott:** Explaining his opposition to expanding Medicaid for the residents of his state, Governor Scott stated that "since Florida is legally allowed to opt out, that's the right decision for our citizens.[3] He added: "It will be a big job-killer because it will cost too much."[4]

- **North Carolina Governor Pat McCrory:** Explaining his opposition to expanding Medicaid in his state, Governor McCrory stated: "I will not sacrifice quality care for the people truly in need, nor risk further budget overruns by expanding an already broken system."[5]

In contrast to your Republican colleagues, you have supported expanding Medicaid for the constituents of your state, stating that it "will extend cost-effective care to Arizona's working poor, using the very tax dollars our citizens already pay to the federal government." You added that it "will help prevent our rural and safety-net hospitals from closing their doors" and "will boost our economy by creating more than 20,000 jobs at a time when Arizona needs them most."[6]

The data obtained by the Committee indicates that by expanding Medicaid in your state, you will be providing medical coverage to approximately 51,000 more residents,[7] adding nearly

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[2] *Some GOP Governors Embrace Medicaid Expansion*, Wall Street Journal (Nov. 21, 2013) (online at http://blogs.wsj.com/washwire/2013/11/21/some-gop-governors-embrace-medicaid-expansion/).

[3] Office of the Governor, State of Florida, *Florida Won't Implement Optional Portions of Obamacare* (July 1, 2012) (online at www.flgov.com/2012/07/01/florida-wont-implement-optional-portions-of-obamacare/).

[4] *Fox and Friends*, Fox News (Mar. 26, 2012) (online at www.youtube.com/watch?v=TaC0mKApf9Q&feature=youtu.be).

[5] Office of the Governor, State of North Carolina, *Governor McCrory: No Special Session to Further Expand Obamacare* (Oct. 28, 2013) (online at www.governor.state.nc.us/newsroom/press-releases/20131028/governor-mccrory-no-special-session-further-expand-obamacare).

[6] Office of the Governor, State of Arizona, *Statement from the Governor Jan Brewer: Arizona Legislature Completes its Work on the State Budget, Medicaid* (June 13, 2013) (online at http://azgovernor.gov/dms/upload/PR_061313_MedicaidRestorationApproved.pdf).

[7] Kaiser Family Foundation, *The Cost of Not Expanding Medicaid* (July 2013) (online at http://kaiserfamilyfoundation.files.wordpress.com/2013/07/8457-the-cost-of-not-expanding-medicaid4.pdf).

4,700 new jobs through 2017,[8] and receiving more than $10 billion in federal funds from 2013 to 2022.[9]

Many healthcare providers in your state support the expansion of Medicaid under the Affordable Care Act. Arizona State University, Northern Arizona University, the University of Arizona, and the Arizona Board of Regents endorsed Medicaid expansion for its potential to relieve state budgetary pressures, even indirectly, to support higher education. The Arizona Board of Regents stated:

> The Medicaid proposal will bring $1.6 billion to the state in enhanced federal matching funds which will greatly reduce pressure on the state budget and constitutional priorities such as higher education.[10]

In order to better understand the basis for your support, I request that you provide by August 22, 2014, copies of any state-specific analyses, studies, or reports that you ordered, requested, or relied on to inform your decision, including specific state-based data relating to the following:

(1) the amounts of federal funding that your state would either receive or forego over the next ten years as a result of your decision;

(2) the projected costs to cover uncompensated care that your state would either pay for itself or receive federal funds to cover over the next ten years as a result of your decision;

(3) the number of direct and indirect jobs that would either be created or foregone over the next ten years as a result of your decision; and

(4) the number of residents in your state that would either receive or forego additional preventative services and other medical care over the next ten years as a result of your decision.

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[8] Kaiser Family Foundation, *A Closer Look at the Impact of State Decisions Not to Expand Medicaid on Coverage for Uninsured Adults* (Apr. 24, 2014) (online at http://kff.org/medicaid/fact-sheet/a-closer-look-at-the-impact-of-state-decisions-not-to-expand-medicaid-on-coverage-for-uninsured-adults/).

[9] Council of Economic Advisors, *Missed Opportunities: The Consequences of State Decisions Not to Expand Medicaid* (July 2, 2014) (online at www.whitehouse.gov/sites/default/files/docs/missed_opportunities_medicaid_0.pdf).

[10] Arizona Board of Regents, *Regents Pass Resolution Supporting Governor's FY14 Budget Recommendations for the Universities and Medicaid Expansion Plan* (Feb. 7, 2013) (online at http://azregents.asu.edu/Lists/Announcements/Attachments/213/Regents%20pass%20resolution%20supporting%20Governor%27s%20FY14%20budget%20proposal.pdf).

Thank you for your cooperation with this request.

Sincerely,

Elijah E. Cummings
Ranking Member

cc: The Honorable Darrell E. Issa
Chairman, House Committee on Oversight and Government Reform

ONE HUNDRED THIRTEENTH CONGRESS

Congress of the United States

House of Representatives

COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM

2157 RAYBURN HOUSE OFFICE BUILDING

WASHINGTON, DC 20515–6143

MAJORITY (202) 225–5074
FACSIMILE (202) 225–3974
MINORITY (202) 225–5051

http://oversight.house.gov

July 29, 2014

The Honorable Chris Christie
Governor, State of New Jersey
State House
P.O. Box 001
Trenton, NJ 08625

Dear Governor Christie:

The Committee on Oversight and Government Reform is currently examining the roles of state and federal governments in sharing the costs of the Medicaid program. As part of this review, I am writing to request information about your state's decision to expand Medicaid services under the Affordable Care Act to the residents of your state.

When Congress passed the Affordable Care Act, it offered states the ability to expand Medicaid services for their non-elderly constituents with families below 138% of the Federal poverty line. Congress offered to pay 100% of these costs for the first three years, declining gradually to 90% by 2020, with states paying only 10% of these costs. According to the Center for Medicaid and CHIP Services:

> These critical health coverage programs serve millions of families, children, pregnant women, adults without children and also seniors and people living with disabilities. In addition to covering services like doctor's visits, prescription drugs, and preventive care, Medicaid helps seniors and people with disabilities receive long term services and supports in their communities as well as in nursing homes. Together, these programs provide an important foundation for maintaining the health of our nation.[1]

Democratic governors have consistently supported expanding Medicaid under the Affordable Care Act, but Republican governors have disagreed among themselves with widely differing explanations. For example:

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[1] Center for Medicaid and CHIP Services, *Message from the CMCS Director* (online at www.medicaid.gov/About-Us/About-Us.html) (accessed July 27, 2014).

- **Texas Governor Rick Perry:** Explaining his opposition to expanding Medicaid under the Affordable Care Act, Governor Perry stated: "It's like putting 1,000 more people on the Titanic when you knew what was going to happen."[2]

- **Florida Governor Rick Scott:** Explaining his opposition to expanding Medicaid for the residents of his state, Governor Scott stated that "Since Florida is legally allowed to opt out, that's the right decision for our citizens.[3] He added: "It will be a big job-killer because it will cost too much."[4]

- **North Carolina Governor Pat McCrory:** Explaining his opposition to expanding Medicaid in his state, Governor McCrory stated: "I will not sacrifice quality care for the people truly in need, nor risk further budget overruns by expanding an already broken system."[5]

In contrast to your Republican colleagues, you have supported expanding Medicaid for the constituents of your state, stating: "I am proud to have made the decision to expand Medicaid and provide greater access to healthcare for New Jerseyans in need."[6] You reported that expanding Medicaid in New Jersey "will save approximately $227 million in Fiscal Year 2014 alone."[7]

The data obtained by the Committee indicates that by expanding Medicaid in your state, you will be providing medical coverage to approximately 227,000 more residents,[8] adding nearly

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[2] *Some GOP Governors Embrace Medicaid Expansion*, Wall Street Journal (Nov. 21, 2013) (online at http://blogs.wsj.com/washwire/2013/11/21/some-gop-governors-embrace-medicaid-expansion/).

[3] Office of the Governor, State of Florida, *Florida Won't Implement Optional Portions of Obamacare* (July 1, 2012) (online at www.flgov.com/2012/07/01/florida-wont-implement-optional-portions-of-obamacare/).

[4] *Fox and Friends*, Fox News (Mar. 26, 2012) (online at www.youtube.com/watch?v=TaC0mKApf9Q&feature=youtu.be).

[5] Office of the Governor, State of North Carolina, *Governor McCrory: No Special Session to Further Expand Obamacare* (Oct. 28, 2013) (online at www.governor.state.nc.us/newsroom/press-releases/20131028/governor-mccrory-no-special-session-further-expand-obamacare).

[6] Office of the Governor, State of New Jersey, *Governor Chris Christie's Fiscal Year 2015 Budget Address: An Attitude of Choice* (Feb. 25, 2014) (online at www.state.nj.us/governor/news/news/552014/approved/20140225c.html).

[7] Office of the Governor, State of New Jersey, *Governor Christie's Fiscal Year 2015 Budget Address As Prepared for Delivery* (Feb. 26, 2013) (online at www.nj.gov/governor/news/addresses/2010s/approved/20130226.html).

[8] Kaiser Family Foundation, *The Cost of Not Expanding Medicaid* (July 2013) (online at http://kaiserfamilyfoundation.files.wordpress.com/2013/07/8457-the-cost-of-not-expanding-medicaid4.pdf).

17,000 new jobs through 2017,[9] and receiving an additional $15 billion in federal funds over 2013 to 2022.[10]

Many healthcare providers in your state support the expansion of Medicaid under the Affordable Care Act. For example, the Medical Society of New Jersey, the largest physician network in New Jersey, stated:

> Governor Christie's decision to expand Medicaid is a positive step that will create access to health insurance for many uninsured residents. Importantly, this decision will make additional investment in the program possible. This is also an opportunity to align incentives and create a robust network of physicians and other healthcare providers for the Medicaid program.[11]

In order to better understand the basis for your support, I request that you provide by August 22, 2014, copies of any state-specific analyses, studies, or reports that you ordered, requested, or relied on to inform your decision, including specific state-based data relating to the following:

(1) the amounts of federal funding that your state would either receive or forego over the next ten years as a result of your decision;

(2) the projected costs to cover uncompensated care that your state would either pay for itself or receive federal funds to cover over the next ten years as a result of your decision;

(3) the number of direct and indirect jobs that would either be created or foregone over the next ten years as a result of your decision; and

(4) the number of residents in your state that would either receive or forego additional preventative services and other medical care over the next ten years as a result of your decision.

Thank you for your cooperation with this request.

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[9] Council of Economic Advisors, *Missed Opportunities: The Consequences of State Decisions Not to Expand Medicaid* (July 2, 2014) (online at www.whitehouse.gov/sites/default/files/docs/missed_opportunities_medicaid_0.pdf).

[10] Kaiser Family Foundation, *The Cost of Not Expanding Medicaid* (July 2013) (online at http://kaiserfamilyfoundation.files.wordpress.com/2013/07/8457-the-cost-of-not-expanding-medicaid4.pdf).

[11] Medical Society of New Jersey, *Medicaid Reform Proposals for the FY 2015 Budget* (Mar. 1, 2013) (online at http://msnj.wordpress.com/2013/03/01/msnjs-statement-on-nj-medicaid-expansion/).

Sincerely,

Elijah E. Cummings
Ranking Member

cc: The Honorable Darrell E. Issa
Chairman, House Committee on Oversight and Government Reform

July 29, 2014

The Honorable John Kasich
Governor, State of Ohio
Riffe Center, 30th Floor
77 South High Street
Columbus, OH 43215-6117

Dear Governor Kasich:

The Committee on Oversight and Government Reform is currently examining the roles of state and federal governments in sharing the costs of the Medicaid program. As part of this review, I am writing to request information about your state's decision to expand Medicaid services under the Affordable Care Act to the residents of your state.

When Congress passed the Affordable Care Act, it offered states the ability to expand Medicaid services for their non-elderly constituents with families below 138% of the Federal poverty line. Congress offered to pay 100% of these costs for the first three years, declining gradually to 90% by 2020, with states paying only 10% of these costs. According to the Center for Medicaid and CHIP Services:

> These critical health coverage programs serve millions of families, children, pregnant women, adults without children and also seniors and people living with disabilities. In addition to covering services like doctor's visits, prescription drugs, and preventive care, Medicaid helps seniors and people with disabilities receive long term services and supports in their communities as well as in nursing homes. Together, these programs provide an important foundation for maintaining the health of our nation.[1]

Democratic governors have consistently supported expanding Medicaid under the Affordable Care Act, but Republican governors have disagreed among themselves with widely differing explanations. For example:

[1] Center for Medicaid and CHIP Services, *Message from the CMCS Director* (online at www.medicaid.gov/About-Us/About-Us.html) (accessed July 27, 2014).

- **Texas Governor Rick Perry:** Explaining his opposition to expanding Medicaid under the Affordable Care Act, Governor Perry stated: "It's like putting 1,000 more people on the Titanic when you knew what was going to happen."[2]

- **Florida Governor Rick Scott:** Explaining his opposition to expanding Medicaid for the residents of his state, Governor Scott stated that "since Florida is legally allowed to opt out, that's the right decision for our citizens.[3] He added: "It will be a big job-killer because it will cost too much."[4]

- **North Carolina Governor Pat McCrory:** Explaining his opposition to expanding Medicaid in his state, Governor McCrory stated: "I will not sacrifice quality care for the people truly in need, nor risk further budget overruns by expanding an already broken system."[5]

In contrast to your Republican colleagues, you have supported expanding Medicaid for your constituents, stating: "It's going to save lives." You added: "It's going to help people, and you tell me what's more important than that."[6]

The data obtained by the Committee indicates that by expanding Medicaid in your state, you will be providing medical coverage to approximately 446,000 more residents,[7] adding 54,000 new jobs through 2017,[8] and receiving an additional $53 billion in federal funds over 2013 to 2022.[9]

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[2] *Some GOP Governors Embrace Medicaid Expansion*, Wall Street Journal (Nov. 21, 2013) (online at http://blogs.wsj.com/washwire/2013/11/21/some-gop-governors-embrace-medicaid-expansion/).

[3] Office of the Governor, State of Florida, *Florida Won't Implement Optional Portions of Obamacare* (July 1, 2012) (online at www.flgov.com/2012/07/01/florida-wont-implement-optional-portions-of-obamacare/).

[4] *Fox and Friends*, Fox News (Mar. 26, 2012) (online at www.youtube.com/watch?v=TaC0mKApf9Q&feature=youtu.be).

[5] Office of the Governor, State of North Carolina, *Governor McCrory: No Special Session to Further Expand Obamacare* (Oct. 28, 2013) (online at www.governor.state.nc.us/newsroom/press-releases/20131028/governor-mccrory-no-special-session-further-expand-obamacare).

[6] *Some GOP Governors Embrace Medicaid Expansion*, Wall Street Journal (Nov. 21, 2013) (online at http://blogs.wsj.com/washwire/2013/11/21/some-gop-governors-embrace-medicaid-expansion/).

[7] Kaiser Family Foundation, *The Cost of Not Expanding Medicaid* (July 2013) (online at kaiserfamilyfoundation.files.wordpress.com/2013/07/8457-the-cost-of-not-expanding-medicaid4.pdf).

[8] Council of Economic Advisors, *Missed Opportunities: The Consequences of State Decisions Not to Expand Medicaid* (July 2, 2014) (online at www.whitehouse.gov/sites/default/files/docs/missed_opportunities_medicaid_0.pdf).

Many healthcare providers in your state support the expansion of Medicaid under the Affordable Care Act. For example, the Ohio Hospital Association stated:

> By seizing this opportunity, the Governor is helping address the daily challenges faced by thousands of hardworking Ohio families who can't get health insurance and the resulting unsustainable impact on our economy and health care delivery system.[10]

In order to better understand the basis for your support, I request that you provide by August 22, 2014, copies of any state-specific analyses, studies, or reports that you ordered, requested, or relied on to inform your decision, including specific state-based data relating to the following:

(1) the amounts of federal funding that your state would either receive or forego over the next ten years as a result of your decision;

(2) the projected costs to cover uncompensated care that your state would either pay for itself or receive federal funds to cover over the next ten years as a result of your decision;

(3) the number of direct and indirect jobs that would either be created or foregone over the next ten years as a result of your decision; and

(4) the number of residents in your state that would either receive or forego additional preventative services and other medical care over the next ten years as a result of your decision.

Thank you for your cooperation with this request.

Sincerely,

Elijah E. Cummings
Ranking Member

cc: The Honorable Darrell E. Issa
Chairman, House Committee on Oversight and Government Reform

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[9] Kaiser Family Foundation, *The Cost of Not Expanding Medicaid* (July 2013) (online at kaiserfamilyfoundation.files.wordpress.com/2013/07/8457-the-cost-of-not-expanding-medicaid4.pdf).

[10] Ohio Hospital Association, *Gov. Kasich's State Budget Proposal* (Feb. 4, 2013) (online at ohiohospitals.org/OHA/media/Images/News%20and%20Publications/Press%20Releases/Gov-Kasich-s-State-budget-Proposal-2-4-13.pdf).

July 29, 2014

The Honorable Pat McCrory
Office of the Governor
20301 Mail Service Center
Raleigh, NC 27699-0301

Dear Governor McCrory:

The Committee on Oversight and Government Reform is currently examining the roles of state and federal governments in sharing the costs of the Medicaid program. As part of this review, I am writing to request information about your state's decision not to expand Medicaid services under the Affordable Care Act to the residents of your state.

When Congress passed the Affordable Care Act, it offered states the ability to expand Medicaid services for their non-elderly constituents with families below 138% of the Federal poverty line. Congress offered to pay 100% of these costs for the first three years, declining gradually to 90% by 2020, with states paying only 10% of these costs. According to the Center for Medicaid and CHIP Services:

> These critical health coverage programs serve millions of families, children, pregnant women, adults without children and also seniors and people living with disabilities. In addition to covering services like doctor's visits, prescription drugs, and preventive care, Medicaid helps seniors and people with disabilities receive long term services and supports in their communities as well as in nursing homes. Together, these programs provide an important foundation for maintaining the health of our nation.[1]

Democratic governors have consistently supported expanding Medicaid under the Affordable Care Act, but Republican governors have disagreed among themselves, with widely differing explanations. Republican governors who support Medicaid expansion have praised the fact that it will provide critical medical services to millions of their constituents while significantly improving their state budgets. For example:

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[1] *Message from the CMCS Director,* Medicaid.gov (online at www.medicaid.gov/About-Us/About-Us.html) (accessed July 27, 2014).

- **Arizona Governor Jan Brewer:** Explaining her support for expanding Medicaid under the Affordable Care Act, Governor Brewer stated that it "will extend cost-effective care to Arizona's working poor, using the very tax dollars our citizens already pay to the federal government." She added that it "will help prevent our rural and safety-net hospitals from closing their doors" and "will boost our economy by creating more than 20,000 jobs at a time when Arizona needs them most."[2]

- **New Jersey Governor Chris Christie:** Explaining his support for Medicaid expansion in his state, Governor Christie stated: "I am proud to have made the decision to expand Medicaid and provide greater access to healthcare for New Jerseyans in need."[3] He reported that expanding Medicaid "will save approximately $227 million in Fiscal Year 2014 alone."[4]

- **Ohio Governor John Kasich:** Explaining his support for expanding Medicaid in Ohio, Governor Kasich stated: "It's going to save lives." He added: "It's going to help people, and you tell me what's more important than that."[5]

In contrast to your Republican colleagues, you continue to oppose Medicaid expansion, stating: "I will not sacrifice quality care for the people truly in need, nor risk further budget overruns by expanding an already broken system."[6]

The data obtained by the Committee indicates that by expanding Medicaid in your state, you would be providing medical coverage to 377,000 additional residents,[7] adding 40,200 new

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[2] Office of the Governor, State of Arizona, *Statement from the Governor Jan Brewer: Arizona Legislature Completes its Work on the State Budget, Medicaid* (June 13, 2013) (online at http://azgovernor.gov/dms/upload/PR_061313_MedicaidRestorationApproved.pdf).

[3] Office of the Governor, State of New Jersey, *Governor Chris Christie's Fiscal Year 2015 Budget Address: An Attitude of Choice* (Feb. 25, 2014) (online at www.state.nj.us/governor/news/news/552014/approved/20140225c.html).

[4] Office of the Governor, State of New Jersey, *Governor Christie's Fiscal Year 2015 Budget Address As Prepared for Delivery* (Feb. 26, 2013) (online at www.nj.gov/governor/news/addresses/2010s/approved/20130226.html).

[5] *Some GOP Governors Embrace Medicaid Expansion*, Wall Street Journal (Nov. 21, 2013) (online at http://blogs.wsj.com/washwire/2013/11/21/some-gop-governors-embrace-medicaid-expansion/).

[6] Office of the Governor, State of North Carolina, *Governor McCrory: No Special Session to Further Expand Obamacare* (Oct. 28, 2013) (online at www.governor.state.nc.us/newsroom/press-releases/20131028/governor-mccrory-no-special-session-further-expand-obamacare).

[7] Kaiser Family Foundation, *The Cost of Not Expanding Medicaid* (July 2013) (online at http://kaiserfamilyfoundation.files.wordpress.com/2013/07/8457-the-cost-of-not-expanding-medicaid4.pdf).

jobs through 2017,[8] and receiving an additional $39 billion in federal funding from 2013 to 2022.[9]

Many healthcare providers in your state support the expansion of Medicaid under the Affordable Care Act. The Republican Mayor of Belhaven, Adam O'Neal, stated: "Without Medicaid expansion, the reimbursements are falling and hospitals like the one in my hometown are on the brink of possibly even closing." He added: "You can't let hospitals close and people die to prove a point."[10]

In order to better understand the basis for your opposition, I request that you provide by August 22, 2014, copies of any state-specific analyses, studies, or reports that you ordered, requested, or relied on to inform your decision, including specific state-based data relating to the following:

(1) the amounts of federal funding that your state would either receive or forego over the next ten years as a result of your decision;

(2) the projected costs to cover uncompensated care that your state would either pay for itself or receive federal funds to cover over the next ten years as a result of your decision;

(3) the number of direct and indirect jobs that would either be created or foregone over the next ten years as a result of your decision; and

(4) the number of residents in your state that would either receive or forego additional preventative services and other medical care over the next ten years as a result of your decision.

Thank you for your cooperation with this request.

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[8] Council of Economic Advisors, *Missed Opportunities: The Consequences of State Decisions Not to Expand Medicaid* (July 2, 2014) (online at www.whitehouse.gov/sites/default/files/docs/missed_opportunities_medicaid_0.pdf).

[9] Kaiser Family Foundation, *The Cost of Not Expanding Medicaid* (July 2013) (online at http://kaiserfamilyfoundation.files.wordpress.com/2013/07/8457-the-cost-of-not-expanding-medicaid4.pdf).

[10] *Advocating for Medicaid Expansion at the Legislature*, North Carolina Health News (June 5, 2014) (online at www.northcarolinahealthnews.org/2014/06/05/advocating-for-medicaid-expansion-at-the-legislature/).

Sincerely,

Elijah E. Cummings
Ranking Member

cc: The Honorable Darrell E. Issa
Chairman, House Committee on Oversight and Government Reform

July 29, 2014

The Honorable Rick Perry
Governor, State of Texas
P.O. Box 12428
Austin, TX 78711-2428

Dear Governor Perry:

The Committee on Oversight and Government Reform is currently examining the roles of state and federal governments in sharing the costs of the Medicaid program. As part of this review, I am writing to request information about your state's decision not to expand Medicaid services under the Affordable Care Act to the residents of your state.

When Congress passed the Affordable Care Act, it offered states the ability to expand Medicaid services for their non-elderly constituents with families below 138% of the Federal poverty line. Congress offered to pay 100% of these costs for the first three years, declining gradually to 90% by 2020, with states paying only 10% of these costs. According to the Center for Medicaid and CHIP Services:

> These critical health coverage programs serve millions of families, children, pregnant women, adults without children and also seniors and people living with disabilities. In addition to covering services like doctor's visits, prescription drugs, and preventive care, Medicaid helps seniors and people with disabilities receive long term services and supports in their communities as well as in nursing homes. Together, these programs provide an important foundation for maintaining the health of our nation.[1]

Democratic governors have consistently supported expanding Medicaid under the Affordable Care Act, but Republican governors have disagreed among themselves, with widely differing explanations. Republican governors who support Medicaid expansion have praised the fact that it will provide critical medical services to millions of their constituents while significantly improving their state budgets. For example:

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[1] *Message from the CMCS Director,* Medicaid.gov (online at www.medicaid.gov/About-Us/About-Us.html) (accessed July 27, 2014).

- **Arizona Governor Jan Brewer:** Explaining her support for expanding Medicaid under the Affordable Care Act, Governor Brewer stated that it "will extend cost-effective care to Arizona's working poor, using the very tax dollars our citizens already pay to the federal government." She added that it "will help prevent our rural and safety-net hospitals from closing their doors" and "will boost our economy by creating more than 20,000 jobs at a time when Arizona needs them most."[2]

- **New Jersey Governor Chris Christie:** Explaining his support for Medicaid expansion in his state, Governor Christie stated: "I am proud to have made the decision to expand Medicaid and provide greater access to healthcare for New Jerseyans in need."[3] He reported that expanding Medicaid in his state "will save approximately $227 million in Fiscal Year 2014 alone."[4]

- **Ohio Governor John Kasich:** Explaining his support for expanding Medicaid in Ohio, Governor Kasich stated: "It's going to save lives." He added: "It's going to help people, and you tell me what's more important than that."[5]

In contrast to your Republican colleagues, you have strongly opposed expanding Medicaid for the constituents of your state, stating: "It's like putting 1,000 more people on the Titanic when you knew what was going to happen."[6]

The data obtained by the Committee indicates that by expanding Medicaid in your state, you would be providing medical coverage to approximately 1,208,000 more residents,[7] adding

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[2] Office of the Governor, State of Arizona, *Statement from the Governor Jan Brewer: Arizona Legislature Completes its Work on the State Budget, Medicaid* (June 13, 2013) (online at http://azgovernor.gov/dms/upload/PR_061313_MedicaidRestorationApproved.pdf).

[3] Office of the Governor, State of New Jersey, *Governor Chris Christie's Fiscal Year 2015 Budget Address: An Attitude of Choice* (Feb. 25, 2014) (online at www.state.nj.us/governor/news/news/552014/approved/20140225c.html).

[4] Office of the Governor, State of New Jersey, *Governor Christie's Fiscal Year 2015 Budget Address As Prepared for Delivery* (Feb. 26, 2013) (online at www.nj.gov/governor/news/addresses/2010s/approved/20130226.html).

[5] *Some GOP Governors Embrace Medicaid Expansion*, Wall Street Journal (Nov. 21, 2013) (online at http://blogs.wsj.com/washwire/2013/11/21/some-gop-governors-embrace-medicaid-expansion/).

[6] *Id.*

[7] Kaiser Family Foundation, *The Cost of Not Expanding Medicaid* (July 2013) (online at: http://kaiserfamilyfoundation.files.wordpress.com/2013/07/8457-the-cost-of-not-expanding-medicaid4.pdf):

more than 59,000 new jobs through 2017,[8] and receiving more than $65 billion in federal funds from 2013 to 2022.[9]

Many healthcare providers in your state support the expansion of Medicaid under the Affordable Care Act. For example, the Texas Medical Association, the state's largest medical society representing over 47,000 physicians, has explained why expanding Medicaid will help Texas businesses.[10] The Association also launched a GetTexasCovered.com website explaining how Medicaid expansion in Texas would result in "increased workplace efficiency; decreased missed work and time loss; and increased output."[11]

In order to better understand the basis for your opposition, I request that you provide by August 22, 2014, copies of any state-specific analyses, studies, or reports that you ordered, requested, or relied on to inform your decision, including specific state-based data relating to the following:

(1) the amounts of federal funding that your state would either receive or forego over the next ten years as a result of your decision;

(2) the projected costs to cover uncompensated care that your state would either pay for itself or receive federal funds to cover over the next ten years as a result of your decision;

(3) the number of direct and indirect jobs that would either be created or foregone over the next ten years as a result of your decision; and

(4) the number of residents in your state that would either receive or forego additional preventative services and other medical care over the next ten years as a result of your decision.

Thank you for your cooperation with this request.

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[8] Council of Economic Advisors, *Missed Opportunities: The Consequences of State Decisions Not to Expand Medicaid* (July 2, 2014) (online at www.whitehouse.gov/sites/default/files/docs/missed_opportunities_medicaid_0.pdf).

[9] Kaiser Family Foundation, *The Cost of Not Expanding Medicaid* (July 2013) (online at: http://kaiserfamilyfoundation.files.wordpress.com/2013/07/8457-the-cost-of-not-expanding-medicaid4.pdf).

[10] Texas Hospital Association, *Medicaid Expansion is Good for Texas Businesses* (Mar. 2013) (online at http://gettexascovered.com/wp-content/uploads/2013/03/FINAL-Economic-Impact-Medicaid-Expansion.pdf).

[11] Texas Hospital Association, *Medicaid Expansion Economic Impact* (online at http://gettexascovered.com/index.php/medicaid-expansion-economic-impact) (accessed on July 27, 2014).

Sincerely,

Elijah E. Cummings
Ranking Member

cc: The Honorable Darrell E. Issa
Chairman, House Committee on Oversight and Government Reform

July 29, 2014

The Honorable Rick Scott
Office of the Governor, State of Florida
The Capitol
400 S. Monroe St.
Tallahassee, FL 32399-0001

Dear Governor Scott:

The Committee on Oversight and Government Reform is currently examining the roles of state and federal governments in sharing the costs of the Medicaid program. As part of this review, I am writing to request information about your state's decision not to expand Medicaid services under the Affordable Care Act to the residents of your state.

When Congress passed the Affordable Care Act, it offered states the ability to expand Medicaid services for their non-elderly constituents with families below 138% of the Federal poverty line. Congress offered to pay 100% of these costs for the first three years, declining gradually to 90% by 2020, with states paying only 10% of these costs. According to the Center for Medicaid and CHIP Services:

> These critical health coverage programs serve millions of families, children, pregnant women, adults without children and also seniors and people living with disabilities. In addition to covering services like doctor's visits, prescription drugs, and preventive care, Medicaid helps seniors and people with disabilities receive long term services and supports in their communities as well as in nursing homes. Together, these programs provide an important foundation for maintaining the health of our nation.[1]

Democratic governors have consistently supported expanding Medicaid under the Affordable Care Act, but Republican governors have disagreed among themselves, with widely differing explanations. Republican governors who support Medicaid expansion have praised the fact that it will provide critical medical services to millions of their constituents while significantly improving their state budgets. For example:

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[1] *Message from the CMCS Director,* Medicaid.gov (online at www.medicaid.gov/About-Us/About-Us.html) (accessed July 27, 2014).

- **Arizona Governor Jan Brewer:** Explaining her support for expanding Medicaid under the Affordable Care Act, Governor Brewer stated that it "will extend cost-effective care to Arizona's working poor, using the very tax dollars our citizens already pay to the federal government." She added that it "will help prevent our rural and safety-net hospitals from closing their doors" and "will boost our economy by creating more than 20,000 jobs at a time when Arizona needs them most."[2]

- **New Jersey Governor Chris Christie:** Explaining his support for Medicaid expansion in his state, Governor Christie stated: "I am proud to have made the decision to expand Medicaid and provide greater access to healthcare for New Jerseyans in need."[3] He reported that expanding Medicaid in his state "will save approximately $227 million in Fiscal Year 2014 alone."[4]

- **Ohio Governor John Kasich:** Explaining his support for expanding Medicaid in Ohio, Governor Kasich stated: "It's going to save lives." He added: "It's going to help people, and you tell me what's more important than that."[5]

In contrast to your Republican colleagues, you oppose Medicaid expansion, stating: "It will be a big job-killer because it will cost too much."[6] You also stated: "Since Florida is legally allowed to opt out, that's the right decision for our citizens."[7]

The data obtained by the Committee indicates that by expanding Medicaid in your state, you would be providing medical coverage to an additional approximately 848,000 residents,[8]

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[2] Office of the Governor, State of Arizona, *Statement from the Governor Jan Brewer: Arizona Legislature Completes its Work on the State Budget, Medicaid* (June 13, 2013) (online at http://azgovernor.gov/dms/upload/PR_061313_MedicaidRestorationApproved.pdf).

[3] Office of the Governor, State of New Jersey, *Governor Chris Christie's Fiscal Year 2015 Budget Address: An Attitude of Choice* (Feb. 25, 2014) (online at www.state.nj.us/governor/news/news/552014/approved/20140225c.html).

[4] Office of the Governor, State of New Jersey, *Governor Christie's Fiscal Year 2015 Budget Address As Prepared for Delivery* (Feb. 26, 2013) (online at www.nj.gov/governor/news/addresses/2010s/approved/20130226.html).

[5] *Some GOP Governors Embrace Medicaid Expansion*, Wall Street Journal (Nov. 21, 2013) (online at http://blogs.wsj.com/washwire/2013/11/21/some-gop-governors-embrace-medicaid-expansion/).

[6] *Fox and Friends*, Fox News (Mar. 26, 2012) (online at www.youtube.com/watch?v=TaC0mKApf9Q&feature=youtu.be).

[7] Office of the Governor, State of Florida, *Florida Won't Implement Optional Portions of Obamacare* (July 1, 2012) (online at http://www.flgov.com/2012/07/01/florida-wont-implement-optional-portions-of-obamacare/).

adding 63,800 new jobs through 2017,[9] and receiving more than $66 billion in federal funds from 2013 to 2022.[10]

Many healthcare providers in your state support the expansion of Medicaid under the Affordable Care Act. For example, the Florida Hospital Association launched TheFlordiaRemedy.com to highlight patient and business support of Medicaid expansion. The Association also endorsed a report from the University of Florida entitled *UF Study: Job, Wages Boosted through Extending Health Care Coverage*.[11]

In order to better understand the basis for your opposition, I request that you provide by August 22, 2014, copies of any state-specific analyses, studies, or reports that you ordered, requested, or relied on to inform your decision, including specific state-based data relating to the following:

(1) the amounts of federal funding that your state would either receive or forego over the next ten years as a result of your decision;

(2) the projected costs to cover uncompensated care that your state would either pay for itself or receive federal funds to cover over the next ten years as a result of your decision;

(3) the number of direct and indirect jobs that would either be created or foregone over the next ten years as a result of your decision; and

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[8] Kaiser Family Foundation, *The Cost of Not Expanding Medicaid* (July 2013) (online at: http://kaiserfamilyfoundation.files.wordpress.com/2013/07/8457-the-cost-of-not-expanding-medicaid4.pdf).

[9] Council of Economic Advisors, *Missed Opportunities: The Consequences of State Decisions Not to Expand Medicaid* (July 2, 2014) (online at www.whitehouse.gov/sites/default/files/docs/missed_opportunities_medicaid_0.pdf).

[10] Kaiser Family Foundation, *The Cost of Not Expanding Medicaid* (July 2013) (online at: http://kaiserfamilyfoundation.files.wordpress.com/2013/07/8457-the-cost-of-not-expanding-medicaid4.pdf).

[11] Florida Hospital Association, *UF Study: Jobs, Wages Boosted Through Extending Health Care Coverage* (Mar. 3, 2013) (online at www.floridaremedy.com/?p=1485).

Thank you for your cooperation with this request.

Sincerely,

Elijah E. Cummings
Ranking Member

cc: The Honorable Darrell E. Issa
Chairman, House Committee on Oversight and Government Reform

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